Community-Based Approaches To Child Health:

BASICS Experience to Date

Edited by

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BASICS

BASICS

BASICS is a global child survival support project funded by the Office of Health and Nutrition of the Bureau for Global Programs, Field Support, and Research of the U.S. Agency for International Development (USAID). The Agency's Child Survival Division provides technical guidance and assists in strategy development and program implementation in child survival, including interventions aimed at child morbidity and infant and child nutrition.

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Abstract

The Basic Support for Institutionalizing Child Survival (BASICS) Project held a workshop at its headquarters to review and analyze community-based approaches being implemented in its country programs and to attempt to develop a framework for BASICS's future role in this area. Programs in Madagascar, Nigeria, Zambia, Honduras, Ethiopia, Bolivia, Bangladesh, and India were represented. Although relatively new, BASICS's community experience suggests some key elements and strategies to ensure the success of child survival programs. Coordination and partnerships at national, district, and community levels among ministries of health and other relevant ministries, NGOs/PVOs, donors, private/commercial sector, and media are keys to planning successful community-based programs. Research and technical analysis as the foundation for matching program interventions to local capacity and resources are crucial to success as well. Community participation in needs assessment and planning and implementation processes can generate not only self-reliance and a sense of ownership in the community, but can also ensure that programs are effective, replicable, and sustainable in the long term and can be scaled up to achieve greater impact on child survival at the community level, where it counts.

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Acronyms

ACCESO	Plan de Acces (Government of Hondura's program to improve social services)
AIMI	Africa Integrated Malaria Initiative
AIN	Atención Integral al Niño (integrated child care program)
ANC	antenatal clinic
ARI	acute respiratory infection
BASICS	Basic Support for Institutionalizing Child Survival
BC	breastfeeding counselor
CBD	community-based distributor
CBO	community-based organization
CBoH	central board of health
CDC	Centers for Disease Control and Prevention
CHA	community health agent
CHP	community health practitioner
CHW	community health worker
CMAZ	Churches Medical Association of Zambia
CPH	community partners for health
DALY	disability adjusted life years
DDC	diarrheal disease control
DHS	Demographic and Health Survey
EHP	environmental health project
EPI	Expanded Program on Immunization
GMP	growth monitoring and promotion program
HC	health center
HF	health facility
HIS	health information system
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
IEC	information, education, and communication
IGA	income-generating activity
IMCI	integrated management of childhood illness
IMR	infant mortality rate
LLLG	La Leche League Guatemala
LLLI	La Leche League International
LQAS	lot quality assurance sampling
M&E	monitoring and evaluation
MOH	ministry of health
MOU	memorandum of understanding
NGO	nongovernmental organization
NHC	neighborhood health committee
ORT	oral rehydration therapy
PA	participatory appraisal
PACT-CRH	Program for Advancement of Commercial Technology-Child and Reproductive Health
PLA	participatory learning appraisal

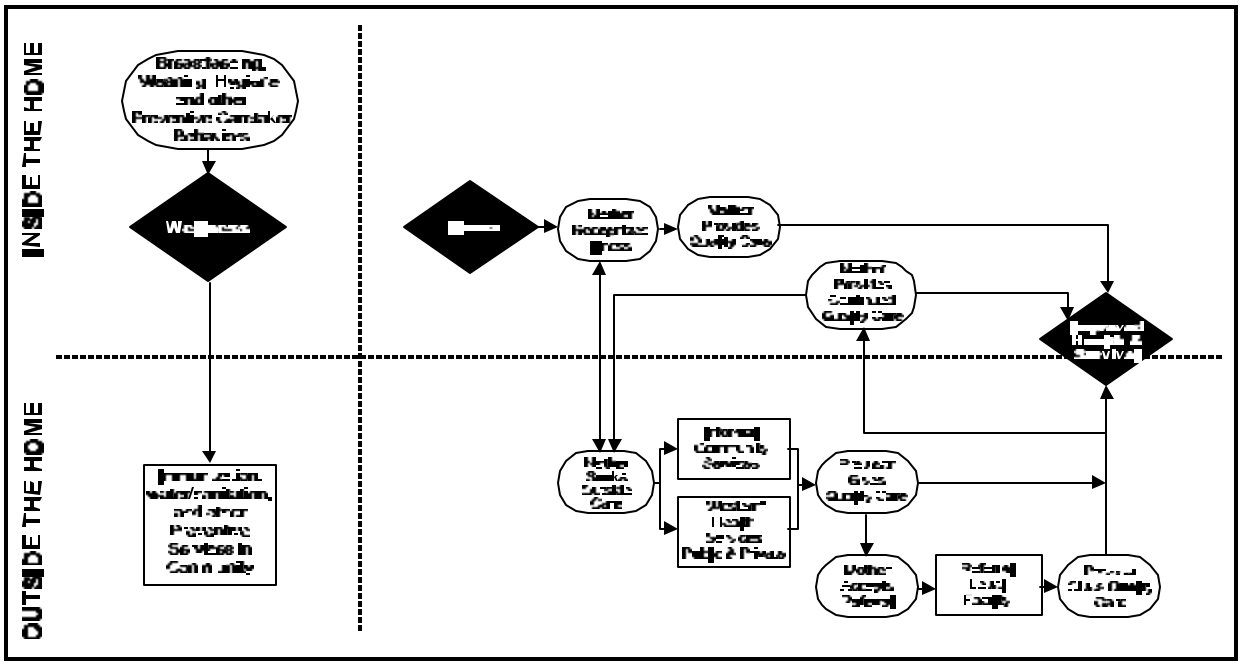
PRA	participatory rural appraisal
PSI	Population Services International
PTA	parent-teacher association
PVO	private voluntary organization
RAP	rapid assessment procedures
SARA	Support for Analysis and Research in Africa
STD	sexually transmitted disease
TBA	traditional birth attendant
TDR	Division of Tropical Disease Research (WHO)
TOT	training of trainers
U2	under 2 years of age
U5	under 5 years of age
UNICEF	United Nations Children's Fund
UPSI	urban private sector inventory
USAID	United States Agency for International Development
VCR	verbal case review
WHO	World Health Organization

Chapter 1
Introduction

Background

The Basic Support for Institutionalizing Child Survival (BASICS) Project is a multidisciplinary five-year international public health project funded by the U.S. Agency for International Development (USAID). It provides technical assistance and support worldwide for reducing infant and child morbidity and mortality. In collaboration with the U.S. Centers for Disease Control and Prevention (CDC) and USAID, BASICS has developed a conceptual framework, called the Pathway to Survival, to assist with the development and monitoring of integrated child health programs. This framework (Figure 1) outlines the key steps by which a child starts out well, develops an illness, and then survives the illness. A substantial component of the Pathway takes place at the level of the home and the community.

Figure 1.
The Pathway to Survival



Over the past two years, BASICS has sharpened its focus on promoting community-level programs to achieve maximum impact on the health of children. The objectives vis-à-vis community-based programs are as follows:

- Achieve greater child health impact at the household and community levels.
- Promote BASICS package of emphasis behaviors.

- Work more effectively with communities on child health issues.
- Identify and promote collective action at the community level to solve or mitigate child health problems.
- Delineate and test models of community actions that can be sustained and replicated.

With these objectives in mind, BASICS organized a two-day workshop to share, review, and analyze community-based approaches being implemented in its country programs and to attempt to develop a framework for future community work. The workshop, held at BASICS headquarters in Arlington, Virginia, September 17–19, 1997, was attended by representatives from eight country programs involved in implementing community-based health activities and from USAID.

The questions posited and explored by the participants during discussions were, How do we know if we are successful? What questions are the best, "most right" to ask? Can BASICS coalesce the positive elements from various community projects to make its program impact exponentially greater? Will rigorous monitoring similar to immunization and integrated management of childhood illness (IMCI) yield replicable models? How do we add value, reduce duplication, and scale up? BASICS has been effective in drawing attention to the importance of involving the community in program processes and in providing leadership at the international, national, and district levels. Can the lessons learned be turned into a useful product that can be shared with various stakeholders to help achieve the objective of improving children's health around the world? The deliberations of the participants yielded useful insights into community work as well as thoughtful suggestions for determining the project's future direction in this area.

Community Workshop

Community components from BASICS programs in eight countries—Madagascar, Nigeria, Zambia, Honduras, Ethiopia, Bolivia, Bangladesh, and India—were reviewed at the workshop. In addition, the community work of several private voluntary organizations (PVOs) with whom BASICS has collaborated on evaluation and documentation was presented and reviewed. These country experiences are summarized in chapter 2.

If community-based programs were to be characterized along a continuum, with greater community autonomy in setting the agenda and in decision-making at one end and none on the other, BASICS programs to date fall somewhere in the middle. In some programs—for example, in Honduras, Madagascar, and Bangladesh—BASICS has approached the community with preidentified goals and sought to "recruit" the community into participatory and supportive roles. Other programs—for example, Nigeria and Zambia—have been more open-ended: Communities were involved in conducting appraisals of the prevailing health situation and developing action plans, with BASICS assistance, which they themselves directly implemented.

Lessons Learned

The meeting participants identified a number of important lessons from BASICS experience. Chapter 3 summarizes the lessons gleaned from subgroup discussions about planning and implementation issues, monitoring and evaluation, and scaling up.

Planning and Implementation

Five key elements in the process of planning community-based programs were identified by the group:

- Coordination with existing programs
- Involvement of all stakeholders, including the community, in the planning process
- Technical analysis
- Assessment of the feasibility of community-level implementation
- Flexible, iterative planning

The group also identified eight overall strategies for achieving greater community involvement:

- Facilitate community participation in selecting program goals.
- Make the community a partner in health sector reform.
- Foster the community's sense of ownership.
- Foster interaction between nongovernmental organizations and the Ministry of Health.
- Foster alliances and partnerships among all stakeholders.
- Foster health system collaboration with other sectors.
- Build incrementally, using a single-focus intervention as an entry point as well as to demonstrate success.
- Use incentives to ensure retention and enthusiasm of community workers.

In addition, 18 specific community-involvement strategies were identified, including community volunteers, folk communication channels, and microenterprise development. Table 3 presents these strategies, giving the country or countries where they have been used, and includes a brief description as well as tools and methods used for each.

Scaling Up

In discussing strategies for scale-up, the meeting participants agreed that BASICS thinking should go beyond the identification of particular community programs that can be replicated elsewhere. While this is one approach, BASICS should be concerned with a more comprehensive focus on building and institutionalizing a system for supporting community programs at a scale appropriate to the given country's situation and capacity. This will require interventions at multiple levels; as with the development of more effective community involvement strategies, partnerships will be essential. Key partners identified for scaling up programs—that is, for achieving greater impact at the community level—are ministries of health, other ministries with a community-level presence (e.g., education, agriculture), donors, nongovernmental organizations (NGOs), private health providers, the private commercial sector, and media organizations.

Conclusions and Recommendations

Chapter 4 summarizes the conclusions arrived at by the group and proposes a framework for BASICS community work in the future. Meeting participants discussed criteria that should be used for judging the success of the project's community programs in the future. It was generally acknowledged that BASICS work in this area is relatively new and still evolving; it thus may be premature to try to establish a definitive list of indicators of success. It was further acknowledged that BASICS functions in a particular context—as a USAID health project working with and through national governments. There are clear limits to what BASICS can offer communities, both in terms of content and process. Given these limits, BASICS should aspire to meet certain criteria in programming its country activities in the future. In addition to focusing on the strategies and lessons described above, BASICS should attempt to ensure that its community-based work is—

- Effective, that is, achieves impact on health behaviors
- Replicable
- Sustainable
- Participatory, to the maximum extent possible within existing constraints

Each of these criteria on its own may be difficult to satisfy, and the pursuit of one may be at cross-purposes with another—for example, effectiveness versus sustainability. BASICS should nonetheless define approaches that attempt to achieve or at least strike a balance among all of these criteria if the project is to move beyond old community participation paradigms and provide leadership in this important area.

BASICS should continue to focus its attention at the national and district levels in country programs, promoting partnerships with PVOs, NGOs, and community-based organizations to support implementation at the community level. It also has a role to play at the global level, partnering with other international

health institutions, including WHO, UNICEF, the World Bank, and the international PVO community. More specifically, BASICS's evolving role includes the following key functions:

- *Policy advocacy and planning* to promote equity and standardize community planning processes
- *Fostering partnerships* between national ministries of health and the private sector, including PVOs, NGOs, private health providers, and the commercial sector
- *Information dissemination* about successful strategies for achieving greater impact at the community level
- *Capacity building* (curriculum development and training) in both public and private institutions to sustain implementation of community-based programs

Chapter 2
BASICS Community-Based Programs

Community Approaches in Madagascar

Presented by Mary Carnell, Country Advisor, BASICS/Madagascar

Background

BASICS/Madagascar is promoting sustainable change at the household and community levels around key child survival behaviors through an information, education, and communication (IEC) program in two types of communities: (1) a cluster of up to 200 rural households called a *fokontany*, and (2) organizations such as religious groups, Boy Scouts, or Red Cross first aid workers. Each government-run IMCI health center serves one commune, composed of 8–12 fokontany. The members of social or community organizations may belong to several of these dispersed clusters.

Strategy

The program has developed a broad range of interventions—from building national capacity through collaboration with the Ministry of Education, donors, and PVOs and the formation of a national IEC task force to counseling cards, radio spots, and community health festivals. The presence of a full-time IEC specialist (who is also a graphic designer) in the country office is a great asset for the program. The focus is on beginning with small, "doable" actions, for example, promoting one or two key health behaviors in a few districts and then gradually scaling up activities and coverage. The plans include developing health worker capacity at the district level by integrating training in interpersonal communication skills and training in the use of printed materials into the ongoing in-service program.

Strategic Underpinnings

Messages. The IEC strategy is based on simple, action-oriented (behavior change) messages with a high health benefit. A "Message Harmonization Workshop," organized by the IEC task force made up of 15 organizations and ministries, produced the core group of messages.

Printed materials. Counseling cards illustrating priority actions being carried out by a typical Malagasy family serve as the front-line communication tool. Each card promotes one health action. The counseling cards are being distributed to all community groups and individuals actively participating in the IEC program. The goal of the counseling cards is to increase program impact by focusing all communication activities on the promotion of priority actions.

Intersectorial approach. The community-based strategy has mobilized not only health workers and nurses but also *encadreurs* (coaches) selected from among community leaders, teachers, extension agents, religious authorities, and other respected community members. Personal communication from a

credible source is the best strategy to encourage "small, doable actions." The coaches are being drilled to include health content in their regular work.

Seasonal themes. The strategy is adapted to a seasonal theme calendar. The period from June through August, being the cold season, is devoted to acute respiratory infection (ARI)-related activities; the theme for the rainy season, which lasts from December through February, is the control of diarrhea.

Implementation

Community-Based Communication Channels

Channel 1: Encadreurs. Eighty encadreurs were selected from the communities associated with IMCI health centers to conduct educational activities. They were trained during three-day training of trainers (TOT) workshops to carry out two primary responsibilities:

- Incorporate the use of counseling cards into their professional work.
- Provide guidance and supervision to community animation committees.

Channel 2: Community animation committees. Social mobilization activities in fokontany associated with IMCI health centers are being managed by community animation committees made up of five to seven members who are identified from among (1) existing well-functioning health groups, (2) existing community organizations such as a women's religious groups, or (3) new committees created from representatives of existing groups. These committees are the link between the district and the community. Members of each committee have been trained in techniques of staging and performing health promotion skits. Each team has set weekly performance goals. At a later stage in the program, they may also be trained to do growth monitoring and oral rehydration therapy (ORT) demonstrations in their communities.

Channel 3: Community organizations. Volunteers from existing community organizations, such as religious, women's, and youth groups, parent-teacher associations (PTA), are also being trained in the use of counseling cards for peer and child-to-child counseling. Channel 3 crosscuts channel 2, but it is not limited to select household clusters associated with IMCI health centers. For example, Red Cross community agents, trained in July 1997 in the use of counseling cards, came from 20 fokontany, of which perhaps 2 or 3 are covered by community animation committees.

Channel 4: Amis de Santé. The plan calls for peer education using positive deviants in the communities. Villagers who are already carrying out certain priority health actions will be identified and invited to form a grassroots network of respected parents, called Amis de Santé, to serve as models and community resources. The effectiveness of this channel will require a creative selection process and a diverse, engaging program that has small built-in motivational factors. For example, if BASICS is promoting five priority health behaviors at the community level, perhaps a family would have to be practicing four of these behaviors before being invited to join this group.

The guiding principles of Amis de Santé are that *membership is earned* and that it also *entails responsibilities*. Therefore it becomes a natural response for village parents to visit an Ami de Santé if they feel they need advice (e.g., "My baby has a cough, what should I do?"). At present, thought is being given to having the first cadre of Amis de Santé visit mothers with newborns to encourage and support exclusive breastfeeding. We anticipate opening this channel in October 1997.

Channel 5: Primary schools. BASICS/Madagascar has recently begun collaborating with the Ministry of Education on the development of a child-to-child and school-to-community program. A draft guide will be introduced to 24 pilot schools in December 1997.

Channel 6: Rural radio. To date, 30 spots developed around three themes—vaccination, ARI, and exclusive breastfeeding—have been produced and are being broadcast on seven regional FM stations. Village skits, health songs, and interviews will also be recorded and broadcast as a means of reinforcing key messages and further motivating community teams.

Additional IEC Activities and Materials

Activities designed to increase vaccination coverage were used to jump-start the IEC program in February 1997. The program included a number of innovative and motivational elements, which have been well received by the communities and form an important part of the IEC effort.

Silk-screened flags. These specially designed flags are being flown under the Malagasy colors to indicate the approach of vaccination days. Flags are displayed at health centers, markets, schools, post offices, and other public locations.

Brevet de protection. Self-adhesive "diplomas" are given to mothers who complete the vaccination series before their child's first birthday. Parents are encouraged to affix the sticker to their front door as a symbol of pride and to encourage grassroots communication.

Radio spots. Rural radio announcements promote the diplomas and explain the significance of the flags.

Health festivals. Following four to five months of community activities, a series of health festivals will be organized. Each festival will bring five to eight communities together for an exchange of ideas. It will also provide a forum for publicly recognizing dynamic individuals and groups as "health friends" and "child-friendly" and for relaunching community activities. The mass media will be invited to cover the festivals.

Health card. The IEC task force is developing a family-friendly health card—one that is easily understood by preliterate villagers.

Child survival logo. A new child survival logo depicting proud parents with a healthy baby has been developed.

***Gazety*.** An informational newsletter for community mobilizers is printed as an insert in rural journals. To date, three editions of 1,500 copies each have been published on the themes of vaccination, ARI, and breastfeeding.

Evaluation

Before the IEC program was launched in February 1997, a baseline household survey was carried out in November 1996. A final evaluation is scheduled for mid-1998. Monthly supervision and monitoring is being conducted by BASICS field staff with Ministry of Health personnel. The survey instrument for the final evaluation will permit a comparison between fokontany that have benefited from intensive community-based activities and those that have received less input.

Lessons Learned

The community program has been launched only recently. One of the overall goals is to learn more about the dynamics of sustaining community mobilization. The following are a few lessons learned and observations to date.

Vaccination flags have been well received by the people. They cost mere pennies per vaccinated child and are a cost-effective way to significantly boost vaccination coverage. After three months of using the flag strategy, some areas show increases in vaccination coverage of up to 50 percent.

Community mobilizers have accepted the concept of action-oriented messages quite easily. The rural population has had little difficulty understanding the need to promote health actions as opposed to the transfer of knowledge-based messages such as a vaccination calendar or food groups.

Printed materials can be put to multiple uses. The same set of counseling cards is being used by health workers, coaches, and community groups. Each card contains only the essential information needed to promote a specific health action. Cards also serve as briefing materials for the development of radio spots and provide a focus for village skits.

Village skits promote local initiative. Although the skits have been under way for less than two months, we have already seen a lot of grassroots creativity. Costumes, props, music, and interactive discussions between actors and the audience have all been introduced by the village teams on their own initiative. It has, however, been observed that some teams are trying to communicate several health messages in each skit. In the coming months, we will focus on refining the approach being used by the teams.

The right community environment can promote behavior change. During the coming year, the staff expects to learn a great deal about how community-based channels can most effectively complement and reinforce each other. The approach so far has been to give a specific activity assignment to each community group and to carefully avoid overloading any one of them.

Community Partnership Experience in Nigeria

Presented by Samuel A. Orisasona, Community Development Program Officer, BASICS/Nigeria

Background

The unstable political climate in Nigeria in the early ’90s resulted in its decertification by the U.S. Congress for receipt of foreign aid. BASICS, which at the time had just begun to implement an urban immunization program in collaboration with the government, forged an alliance with the private sector and community-based organizations (CBOs) to improve maternal and child health services and home health practices in large, underserved, high-risk urban communities in Lagos State. The mandate is to develop and test a sustainable community-based model to improve the quality, coverage, and management of private nongovernmental health services; foster increased community demand for quality services; and engender in the community responsibility for and involvement in its own health.

Objectives

With the overall goal of reducing child morbidity and mortality, the project has been working to meet five major objectives:

- Strengthen organizational management and planning in the private sector through community partnerships.
- Improve preventive practices and home-based care for the sick child in target communities.
- Improve the quality and coverage of IMCI services (initially focusing on immunization, later on maternal and child health) and reproductive health services provided by private sector health facility partners.
- Strengthen and expand the role of women in leadership and decision-making in the project constituencies and service communities.
- Disseminate lessons learned nationally and in the region and transfer materials, methodologies, and systems dealing with private sector community partnerships to other urban sites.

Strategies

BASICS helped develop a model, called the Community Partners for Health (CPH), that brings together community-based organizations and private health facilities (HFs) to identify issues affecting child health in the community, set priorities, and develop and implement action plans to address identified problems.

Urban Private Sector Inventory

In the absence of a database or other records, BASICS developed a tool, the urban private sector inventory (UPSI), to identify and interview CBOs, HFs, pharmacies, and patent medicine vendors in 13 communities. The results were augmented with information collected from interviews with community leaders and other informants as well as from a rapid street assessment and visual survey of the communities. The information from the UPSI was initially used to select six target communities with a total population of nearly 1 million, 144 HFs, and 241 CBOs.

Community Fora

Over a period of six months, the project held 34 fora in the selected communities for representatives from 74 HFs and 90 CBOs. The invitations to the fora were hand-delivered, which may have been one reason for the high attendance at these gatherings. The fora introduced the project and its goal and objectives, identified community health problems, explained the concept of the Pathway to Survival, explored the feasibility of partnerships, identified potential partners (based on geographical proximity), discussed future steps, and defined the roles and responsibilities of each partner. To facilitate implementation, BASICS proposed prototype dyads, that is, partnerships between one or more HFs and three or more CBOs.

The fora not only used participatory methods to stimulate discussion and free interchange of ideas, but also modeled good meeting and organizational techniques. By the end of the second round of fora, dyads had formed in each of the six communities. These six pilot CPHs have an initial outreach of approximately 250,000 people; the potential coverage is estimated to be several million.

Implementation

Governance and Management

The six pilot partnerships, or dyads, include a total of 15 HFs and 42 CBOs; each has its own unique membership configuration and therefore had to reach consensus on its governance and fiscal responsibility. Initially, the CPHs were not legal entities, so the status of the member organizations was not affected by the partnership. However, each CPH established a governing board to implement and monitor health activities that would be agreed upon in its action plan. Basically, each participating partner followed its own selection process and criteria for contributing one member to the board. The board members then chose a chair or cochairs to make executive decisions and assume financial responsibility for the CPH.

The CPHs have adopted formal names, and each has established a secretariat to maintain minutes of meetings and other communications and to provide logistical support. Some CPHs have funded a part-time staff position for these functions, and others provide in-kind support. The partners also provide meeting space and equipment; these are often rotated among the members, but in some cases they are sponsored primarily by a “leading” partner, commonly the HF. The CPHs used existing organizational structures and resources instead of investing in new ones. Individual memoranda of understanding (MOU) were drawn between each member organization and the partnership as the implementing mechanism for

their action plans. In addition, an MOU was developed between each CPH and BASICS. The CPHs have been registered, and each has established a financial agent.

Work Plan Development Workshops

A series of three workshops, one per two CPHs and lasting one and a half days, was held. In the workshops, the CPHs were able to refine partnership objectives, develop activities to meet these objectives, create work plans, and draw up budgets. Generally, each work plan consists of three core objectives directed toward improving child health through prevention and treatment of diarrhea, malaria, ARI, or measles. Two additional core objectives are aimed at strengthening institutional capacity through ensuring sustainability of services and empowerment of women.

Subproject Proposals

These proposals, based on the work plans, were submitted to USAID for approval and funding. The three-year grant proposals focus on outcomes that the CPHs hope to accomplish through improved communication, training, increased supply of vaccines, and the like.

The following activities are in various stages of progress:

- IEC materials development and production
- Traditional birth attendant (TBA) master trainers' training for 25 participants from Lagos and Kano and 2 from each of the other implementing partners
- MOUs between HFs and TBAs
- Ongoing democracy and governance training: 100 per CPH, 600 per mock parliament
- CPHs' registration
- Income-generating activities
- Annual report writing by CPHs
- Process documentation
- Technical report
- IMCI initiation

Evaluation

The UPSI baseline health data will be used by BASICS and the partnerships themselves to monitor results of project interventions.

Lessons Learned

This partnership project, whose viability looked dubious at best less than a year ago, is now providing reasonable grounds for optimism about grassroots initiatives. Despite abysmal social and economic indicators, these high-risk communities are mobilized to help themselves with a collective energy that is amazing. The people are banding together across boundaries of religion, ethnicity, language, education, gender, and age to participate in organized, directed activities to improve the health of their children. They are full of high hopes and determined to succeed. What made this happen? Appropriate technical assistance, experienced consultants, innovative methodology, and excellent tools on the donor side and inspired leadership, high morale, enthusiasm, and energy on the community side seem to have been important ingredients. It would be speculative at this juncture to draw definitive conclusions, but it speaks well for a community-based approach to development.

Specific lessons learned are as follows:

- The model can be replicated at low cost and in a relatively short time, as shown by the experience in the north (Kano).
- Technical assistance rather than transfer of money to individuals or groups is more effective in ensuring long-term impact.
- Incentives (such as the secretariat board package, environmental sanitation, and seed equipment) serve as encouragement to partners.
- Income-generating activities and traditional cooperative system/economic empowerment serve as catalysts by meeting the felt needs of the poorest of the poor women.
- The democracy and governance program is an eye-opener for the partners—its linkage to child survival has been crucial.

Community Partnerships in Zambia

Presented by Elizabeth Burleigh, Technical Officer, BASICS/Zambia

Background

Zambia has one of the highest infant mortality rates in Africa, and recent studies have shown this rate is increasing. Health center staff in both urban and rural areas are overwhelmed by the magnitude of the disease burden presented by illnesses such as malaria, cholera, pneumonia, measles, and HIV/AIDS.

BASICS is working in Zambia to strengthen health worker capacity to deal with these illnesses more effectively through IMCI; however, Zambia stands little chance of reducing its infant mortality significantly until it can focus increased efforts on the prevention of these diseases at the community level.

Community-Based Prevention Program

For the most part, the Ministry of Health (MOH) has not focused efforts on community-based prevention. Although there was some training of community health workers (CHWs), training manuals were not available and the training given by health center (HC) staff was based primarily on curative care. Once the training was completed, the volunteers were given insufficient supplies—and then only infrequently—to implement their tasks, were not given IEC materials, and were rarely if ever supervised. As volunteers, they were also given unrealistic populations of up to 20,000 persons (3,000+ households) to cover. In spite of this, CHWs attempt to provide some care to their communities, and communities often give donations of scarce maize to show their appreciation, in some cases building a structure in the village for the volunteers' use.

The principal paradigm followed by the MOH in community-level prevention in Zambia has been one of outreach rather than empowerment of communities and community volunteers. According to the outreach model, the health center and district staff go out into the community sporadically to directly implement prevention activities such as group education, building of latrines, or immunization. Once the specific prevention activity is completed, the health center staff return to the health center until another outreach activity is planned, leaving the community to await the next visit.

In the past, the MOH also has not emphasized working in partnership with either the private sector or NGOs. There are many international and national NGOs working in both rural and urban areas of Zambia. However, with the exception of a few international NGOs and the Zambian NGO network coordinator Churches Medical Association of Zambia (CMAZ), most NGOs do not ask the ministry for advice or coordinate activities to any real extent. Although they cover a broad range of activities, including health, and are of varying strengths, most NGOs tend to seek their own independent sources of funding, determine what activities they will undertake, and select the geographic areas they will work in. As a result, there is some mistrust between the ministry and NGO. The ministry feels that many health-related NGOs work in isolation, do not focus on the most important health needs, and do not serve the population most at risk.

Under the new health reforms, the Central Board of Health (CBoH) proposes to make some important changes to strengthen community-based prevention in Zambia:

- *Shift from the outreach paradigm of prevention work to that of empowering communities and community volunteers.* Districts and health centers are being encouraged to organize and work closely with peri-urban and rural communities to identify health problems, develop solutions, and empower the community and volunteers to work with the health center to prevent illnesses before they occur.

- *Forge partnerships between the MOH, the private sector, and NGOs.* Districts and health centers are encouraged to identify the private sector and NGOs in their areas and work with them to prevent illnesses and deliver the essential health care package as defined by the health reforms.

Objective

The principal objective of the community-level portion of the BASICS/Zambia Child Health Project is to support the MOH and the new CBoH in creating partnerships to strengthen community-level prevention and assist in the development and implementation of the health reforms.

Strategies

To carry out its objective, the project is supporting and developing two models of community-based prevention and primary health care:

- District–health center–community partnerships in high-risk urban and rural areas

- NGO partnership grants linking NGOs to districts, health centers, and underserved, high-risk rural communities

BASICS is also assisting the CBoH, Lusaka District, and Chipata Health Center and its 20 neighborhood health committees (NHCs) in developing a pilot area to test the new structure of the health sector on the community level. Under this new design, the health center will cease to be the front line of health care in urban and rural areas. Instead, the reform calls for subdividing the health center catchment area (Chipata Health Center covers a population of 240,000) into much smaller catchment areas of 3,000 people or 500 households each.

The Chipata catchment area will be divided into 80 of these smaller units. In each unit, the CBoH will install a health post to be manned by a new cadre of workers—the community health practitioners (CHPs). These persons will become the front line health workers responsible for working with the smaller groups of households and the community volunteers in preventive activities. According to the current thinking, there will be one NHC and ten CHPs per health post. BASICS is working closely with the Lusaka District HC and NHCs to map and divide the catchment area into 80 of these smaller units. Once this is completed, the NHCs will be asked to identify locations for the new health posts.

BASICS is working closely with the CBoH to strengthen policies and guidelines related to community-level prevention, develop national training curricula and materials for CHPs and community volunteers, and develop IEC materials for group and individual education for behavior change.

Implementation

District–Health Center–Community Partnerships Projects

Using this model of partnership between public and private sectors and the community, BASICS has worked with the CBoH to identify four districts in two of the four health regions for the development of these new types of community-level prevention projects. The 14 peri-urban and rural health center areas in the selected districts have a population of 26,200. One district (Kitwe) involves peri-urban communities, while the other three (Chipata, Lundazi, and Chama) are rural.

Kitwe: HC–peri-urban community partnerships. In Kitwe, BASICS is working with the district and with three health centers located in high-risk peri-urban compounds, which were selected by the district as priority areas. In each of the three areas, four zones were in turn selected by the HC as those of highest risk. The total population in each of the three HCs is approximately 5,000 (15,000 in all). Here, BASICS is working jointly with the Environmental Health Project (EHP), Division of Tropical Disease Research (TDR), the Population Services International (PSI) HIV/AIDS project, and the CARE family planning project. Activities focus on malaria and diarrhea prevention, water and sanitation, nutrition, HIV/AIDS, and family planning. To date, the project has accomplished the following:

- A partnership workshop sponsored by the region and the district for the NGOs, the private sector, and other social sector representatives. The purpose of this workshop was to begin to discuss private sector support to the health sector and to coordinate work with NGOs and other sectors.
- Formation of a partnership working group within the district
- Support from Lever Brothers for a health promotion poster to be used by the district
- Development and field-testing of IEC materials (counseling cards) for training NHCs
- Development of a joint household survey instrument by CARE, BASICS, and PSI
- Two-week joint BASICS/PSI/CARE training of district, health center, and community members in participatory appraisal (PA) techniques
- Joint BASICS/PSI/CARE implementation of PA in one HC catchment area. This resulted in a wealth of quantitative and qualitative information, baseline behavioral data (10 percent household survey), and a joint work plan and budget developed by the district, HC, and community.
- Development of proposals and EHP funding of microenterprises in the three HC areas to generate funding for health activities. The projects are designed and managed by the community, and each opens a community bank account. The enterprises include such activities as block making, mosquito net making, and poultry farming.

Chipata, Lundazi, and Chama: Development of HC–rural community partnerships. The project is operating in 14 health centers, located in high-risk rural areas selected as priority by each district. Each of the health centers in turn selected the rural villages that they considered at highest risk. Total population in each of the 14 HCs is approximately 800 (11,200 in all).

The project, working in collaboration with Africa Integrated Malaria Initiative (AIMI) and CDC, is focusing on malaria and diarrhea prevention, water and sanitation, nutrition, antenatal care, immunizations, and family planning. The accomplishments to date are as follows:

- Two-week training of core district and HC trainers in PA techniques, using one district and one HC area as the training site
- Replication of the PA training in the two other districts and two other HC areas with BASICS technical support
- Replication of the PA process by two districts in seven additional HC catchment areas, using trainers trained by BASICS but without BASICS support
- The PA activities also resulted in a wealth of quantitative and qualitative information, baseline behavioral data for each HC area (100 percent household survey in households with children under 2 years of age [U2s], and 10 joint work plans developed by the districts, HCs, and communities.
- Formation of NHCs and selection of CHWs and TBAs for training in all 10 HC areas
- HCs and communities have begun implementation of plans, depending entirely upon HC and district resources. Community-based activities have included immunizations, building of latrines, forming a partnership with a regional agricultural organization to support the growing of ground nuts, chlorination of wells, identification of sources of narrow-necked drinking water containers, and the promotion of their use. One HC has also joined with a local NGO to train community-based distributors (CBDs)—volunteers responsible for distributing family planning methods—and develop family planning in the partnership villages.

NGO Partnership Grants

The second model being developed and supported by BASICS for community-level prevention is that of the NGO Partnership Grants. As noted elsewhere, NGOs and the MOH in Zambia rarely work closely together. This has led to some lack of trust between the two groups. To break down this barrier, BASICS has worked closely with the CBoH, regions, and selected districts to encourage a more proactive approach toward NGO assistance.

These grant projects will provide coverage to an estimated 40,000 people in four rural districts in two regions. They are expected to be medium sized (around $50,000 annually, depending upon the number of technical areas covered and need for fixed assets), and to last three years. All NGOs have been asked to

deliver the key elements of the Essential Health Care Package for the community level as defined in the reforms, including diarrhea, ARI, malaria, HIV/AIDS, immunizations, nutrition, maternal health and family planning, and water and sanitation.

Accomplishments to date include the following:

- The regions have identified the districts that are weakest and most in need of NGO help.
- The selected districts have identified the portions of their catchment areas they feel are at highest risk and that they are unable to adequately cover alone. Three of the four selected districts do not have an NGO.
- Priority districts worked closely together to develop a standard NGO proposal format and selection criteria, as well as presentations to be made at an NGO open forum.
- The USAID Controller's Office added specific pages on financial management to the proposal format and also developed a rating sheet for the selection criteria.
- At an open forum in Lusaka in May 1997 that had been advertised in the media, representatives from the CBoH, regions, and districts spoke of the importance of working together to prevent disease. Each district presented its specific problems and needs and asked the NGOs to submit proposals for projects serving the highest-risk villages in their catchment area. Districts were told that they were in competition for NGOs and were urged to make the most appealing presentation possible to attract the NGOs. Eighty-five NGOs attended the event, and 73 of these took proposal materials with them upon leaving.
- During the next two months, NGOs visited the districts and developed their proposals. The district health management teams took them to the high-risk villages, where they spoke to the leaders and members of the health committees.
- By the end of July 1997, a total of 32 proposals had been received from NGOs for the four priority districts.
- In August, BASICS sponsored an NGO selection workshop. During the workshop, a five- to six-member selection team reviewed all the proposals received for that district. Proposal review was conducted using a blind independent system (all members rated all proposals independently) based on a set of weighted selection criteria developed earlier by the four districts. Thus, each proposal received five to six independent technical scores, which were averaged to determine the final scores. All proposals also were rated by the Controller's Office on the basis of its weighted selection criteria. Therefore, each proposal also received a score for financial management. Once the scores had been tabulated, each district team selected two NGOs as candidates for funding.

- During September, these teams were engaged in visiting the selected NGO candidates. Visits were conducted using a field visit checklist that was developed jointly by all four districts during the selection workshop.

- As districts select the final NGO candidate, the Controller's Office has begun conducting week-long financial management assessments of the NGOs in their offices.

Future Activities

Once the NGOs have been assessed and approved by both USAID and the districts, BASICS will sponsor the first district-NGO partnership workshop to develop the initial plans and budgets, which will cover a three-month startup and training period. Annual plans will be developed by the NGOs, districts, HCs, and communities using PA methodologies once the three-month period is completed. All plans and budgets will be signed by both the NGO and the district, and project implementation will commence following USAID approval.

As a part of the strategy to strengthen the NGO sector in Zambia, USAID and BASICS have decided to concurrently fortify CMAZ as an NGO coordinating body, because it is the only health-specific NGO network in the country with a well-respected membership, it provides a significant percentage of rural health care in Zambia, and it has a working relationship with the MOH and CBoH. With the assistance of the Program for Advancement of Commercial Technology-Child and Reproductive Health (PACT-CRH), BASICS has worked with CMAZ to submit its application to USAID as a registered local NGO, conducted an institutional assessment of CMAZ's capacities, and assisted CMAZ to develop a proposal for USAID funding as network manager. BASICS support to CMAZ will continue in 1998.

Evaluation

BASICS currently has two levels of evaluation of these community-based prevention projects in Zambia: process and impact. We also plan to develop USAID's ability to conduct annual cost-efficiency and cost-effectiveness evaluations of these projects over the next three years under the follow-on USAID project.

Monthly Process Evaluations

We have developed a process checklist that is used to rate the progress of each of the partnership projects, whether they are NGO partnerships or district–HC–community partnerships. There are 38 indicators on the checklist, measuring progress in categories such as partner identification; participatory assessment and planning; formation of partnership committees; selection and training of community, NGO, and HC personnel; supplies and equipment; implementation of plans; reporting; monitoring and supervision; and evaluation. Each indicator is worth a maximum of 3 points (fully completed) and a minimum of 0 (not done at all). There is a possible total, therefore, of 114 points each month. The 7 projects are reviewed each month by a team that includes representatives from BASICS, the district, HC, and community, and they are then given a monthly process rating. On the basis of this evaluation, priorities for action in the coming month are defined, including a target date for completion and the person

responsible. The monthly review is signed by the BASICS field advisor, the community representative, the HC, and the district.

Annual Outcome Evaluations

Quantitative baseline measurements are collected on all partnership projects using a standard semistructured household instrument form. The format includes 29 behavioral indicators relating to the following technical areas: nutrition and growth monitoring, water and sanitation, maternal health, family planning, malaria, care-seeking behavior, management of illness, and medications. In small communities (under 5,000), the instrument is applied in 100 percent of households with U2s, while in larger communities (over 5,000), the instrument is applied in a 10 percent sample of all households. In large communities, the sample is also stratified by wealth categories (as defined by the community) and weighted proportionally. The use of standard baseline indicators will allow a comparison of the outcomes of various projects annually.

Lessons Learned

Communities in Zambia are motivated to work with HCs on community-level prevention and have the necessary ingredients for empowerment—community volunteers who know English and have up to a 5th grade education, willingness to organize into development groups, and willingness to provide in-kind support to prevention activities as well as to volunteers. Districts and HCs throughout Zambia are enthusiastic about participatory appraisal methods and express the desire to be trained. They are optimistic about what they can achieve working with communities on prevention. Districts and NGOs share the general enthusiasm about working together to improve coverage in high-risk, underserved areas. The reform has provided opportunities for BASICS to have significant influence on national policies, nationally distributed technical and planning guidelines, and the development of national training and IEC materials.

Constraints

Zambia has no appropriate community volunteer training materials. The lack of these materials has delayed the development of community projects, especially those in Chipata, Lundazi, and Chama in Eastern Province. BASICS has been working with the CBoH and other technical partners and now has draft training materials, which will hopefully be field-tested in the near future.

There are also no group or individual educational materials to affect behavior change. Once the training of volunteers is complete, they will need to be supplied with IEC materials to implement their work plans. BASICS also has been working with the CBoH and other partners to develop a set of these materials. These are now in draft form and ready for technical review and field-testing. Development of these materials has been slow, due partly to the lack of organization in the CboH and partly to the absence of an IEC resource person (BASICS has now hired an IEC person to accelerate progress in this area).

The district–HC–community projects need additional funding to get their projects off the ground. Districts and HCs especially lack funding for transport, training, and supplies and equipment for the community level. BASICS/Zambia is considering providing this support in the form of district or HC startup grants; however, since we are in our final year, this funding may not be available, an eventuality that could significantly reduce the success of these projects.

Some individuals in the CBoH are uncertain about supporting the NGO-district linkages; this will require further discussions. One person is threatening to reduce the budgets of districts that have NGO partners, a move that would discourage any district from working with an NGO. Fortunately, however, both the minister and deputy minister are in favor of NGO-district projects and may be called upon as allies in the discussion.

Integrated Care of the Child in Honduras

Presented by Victoria de Alvarado, Country Advisor, BASICS/Honduras, and Marcia Griffiths, President, The Manoff Group

Background

The environment in which Atención Integral al Niño (AIN) is being developed is changing constantly, but it is characterized by a strong belief in integrated service delivery and decentralization. Essentially, health decision-making has devolved to the area level (equivalent to district in some other systems). ACCESO (Government of Honduras' plan to improve social services) is involved in a nationwide process of resource reallocation based on area-level plans. AIN offers ACCESO a way of developing community-level action plans upon which to base the area-level plans.

The country has a long history of community health work. A multitude of NGOs are working at the community level, and many government programs over the years have established community promoters to provide services. AIN hopes to provide an umbrella under which many of these promoters might operate, including the NGO promoters.

AIN is a national program that provides priority child health activities at the health center level and in the community. It incorporates a decision-making process, based on monthly assessments of child growth, to tailor integrated child health care to the needs and resources of individual families and communities. AIN's core concept complements the decentralization of the health sector currently under way in the country.

The program began as a pilot in 1993 and has expanded to cover several health regions. The key indicator used in AIN for determining health interventions is whether or not the child is gaining weight. Since the coverage of monthly weighings is higher if the children are weighed in the community, AIN experimented with expansion to the community level in 1994. BASICS has been assisting AIN in this endeavor by helping to develop program standards and integrated systems of assessment and intervention for individual children and communities as a whole. At the health center level, BASICS has assisted with the full

integration of IMCI into AIN. The concurrent work on AIN/IMCI at the facility level and AIN at the community level has afforded some exploration of the community–health facility linkages that are crucial in a national health care delivery system. The community component of AIN is now primed to move into full-scale implementation. BASICS is assisting with this implementation in nine heavily populated health regions of the country that are receiving USAID support.

Goal and Objectives

The main goal of the overall AIN program is the adequate monthly growth (weight gain) of children under 2 years of age (U2s). To achieve this goal, the program is focusing on reducing the incidence and duration of major childhood diseases through full immunization, prompt and appropriate care of the sick child, and optimal child-feeding practices.

Strategies

Seeking to generate an understanding of and dedication to promoting the health and well-being of children at the community level, AIN is establishing small groups of no more than three community volunteers each who will weigh children every month. The groups will work with the caretaker of each child to develop an action plan based on whether the child gained weight in the past month and whether the child is now ill or has been ill during that time.

The monthly weight gain will be used in an analysis of the factors in the community, beyond the influence of individual families, that may affect the health of children. Every four months the community will meet to review data on the growth of their children and related information and will develop a collective action plan to improve the well-being of the community's children. Specific strategies include the following:

- An active in-service training and supervision program to help motivate the community volunteers and upgrade their skills
- Appropriate linkages between the community-level activities and the health center and local channels for resolution of community problems to reduce the workload at the health center
- Individual counseling and negotiation, home visits, and support-group activities to improve child health–related practices at the household level
- Health center protocols to reinforce community education and activities and ensure that referrals are made back to the community

Implementation

To date, AIN is engaged in defining guidelines for a national program that operates on the community level. The mixing of "top-down" and "bottom-up" planning is one of the interesting features of AIN. AIN planners have been very aware of the need for technical guidance on the actions and procedures that are

most likely to have an impact, but they have made a conscious effort to avoid many pitfalls of past programs, such as a lack of flexibility for local programming. AIN has tried to build time and flexibility for community needs assessments and planning into national guidelines. A few features of the community approach used in AIN are described below.

Formative Research

AIN has used formative research to collect data on families in selected communities throughout Honduras to better understand household practices related to specific childhood illnesses and young child feeding. The information has been used to develop technical guidelines and an educational program as a part of AIN. In addition, community needs assessments are conducted in each health area as part of the national ACCESO program. The health center uses the results to identify communities that would be good candidates for AIN (usually the most needy are chosen). Upon joining AIN, each community undertakes mapping, "surveys," and meetings to understand and identify its child health problems by focusing on the growth of its children. The community also selects AIN volunteers among its members as a part of the community involvement process.

Self-Sufficiency

In outlining the relationship between the health center and the community and its volunteer workers, every effort was made to ensure that the health center staff support but do not dominate the community involvement process. The training of volunteers, the network within the community of various types of volunteers, and the community meetings to resolve problems beyond the family are all ways that communities can resolve their own problems without being dependent on the health center. After a planned year of an "internship/training" and close supervision, the health center's ties with the community are loosened substantially.

Community Volunteers as Catalysts

Essential tasks for volunteers have been detailed in a manual that is the springboard for the rest of the program. The volunteers are catalysts for community action, and although they have a core set of responsibilities, their main responsibility is to mobilize others as needed to ensure that all U2s continue to gain adequate weight each month. This may mean organizing collective community action, asking help with home visits, or finding women to facilitate support groups.

Behavior Change Emphasis

AIN places equal emphasis on working at both the individual child/household level and at the collective community level to change practices. Learning from past programs that have often focused on just one approach, AIN is working at two levels in the community: (1) educating families of young children to improve household practices and (2) working with the community as a whole to improve community conditions that favor the health of children.

Applied and Experiential Training

The preservice training of community volunteers and their trainers is thorough, hands-on, and experiential. Training courses are carefully structured to ensure that the trainees will have sufficient grounding in the largely new concepts of preventive health, of detecting child health problems before they become serious,

of negotiating change with the caretaker, and of collective community action to teach others. The five-day preservice training curriculum for the volunteers mirrors their manual, and the curriculum for the seven-day training of the health center nurses (the main contact with the community) is a companion to an implementation manual developed for them and colleagues at a higher level of the health system. Volunteers have a six-hour in-service training session once a month for the first year they are in the program. The training focuses on their perceived problems and the observations of the supervisor.

Expand Slowly and Learn by Doing

Each health center in the program works with only two communities each year. This enables it to provide necessary support and have enough time to train the volunteers in community planning and implementation techniques. As communities gain experience, they will become the models for other communities and can "mentor" those just joining the program. Annual meetings of all volunteers will help promote this exchange and engender enthusiasm.

Validation of Community Effort

AIN will actively showcase community efforts with local authorities to validate its work and to add its voice to local plans. The action plans developed at the community level will be shared with local health officials and the municipal leaders working with ACCESO. This should help ensure the allocation of resources for the communities and thus demonstrate to them that their efforts are being recognized by authorities. The local authorities, on the other hand, will have an opportunity to be responsive to local needs.

Flexibility

AIN is relevant and of interest to many NGOs that work in coordination with government health services but have their programs at the community level. To ensure that the overall framework is adaptable to multiple settings, BASICS looked for an opportunity to work with an NGO willing to implement the AIN community component. CARE has agreed to collaborate and is working with the guidelines in its project areas, which are some of the poorest in Honduras.

Evaluation

Each community will evaluate its own performance against the baseline data it collected upon entering the program. In addition, there is a plan being developed for a large-sample, cost-effectiveness evaluation of the national AIN program.

Lessons Learned

- Key program personnel should have a clear vision of community work and a thorough understanding of the conceptual basis of the work, particularly if they have been working primarily with a curative health model. The AIN model stresses the maintenance of health and wellness. This has not always been readily comprehended by decision-makers.

- Guidelines for the community and the community volunteers should be developed before structuring the responsibilities of health center staff. Ideas may change as the community process is implemented in a few communities, and various responsibilities may have to be shifted around. It is best to set the vision for the community and build on it.

- Attention should be paid to program management, not just the technical features. Factors such as work load, logistics of weighing sessions, and relationships between the volunteers and the head of the community, among many other issues, are at least as important as technical information in ensuring the success of a program, although they are often forgotten.

- Key tools and forms should be developed and tested as part of the process of defining the structure of the program. This step cannot be put off until after the overall design is complete because experience with each tool (e.g., the counseling cards) will shape the program itself.

Community Assessment and Planning: A Participatory Approach in Ethiopia

Presented by Karabi Bhattacharyya, Technical Officer (IEC), BASICS Headquarters, and John Murray, Technical Officer (DDC), BASICS Headquarters

Background

The design of the community assessment and planning process responds to two trends in public health planning. First, there is a trend for primary health care program planning to be decentralized to the district level and away from the national level throughout the world, especially in Africa. Decentralization requires that health planners collect local information to develop strategies and allocate resources. Second, as resources for health become scarce, poor communities are increasingly asked to contribute resources (usually cash, land, and labor) for health services. As a result, there is a recognition among some health planners of the need to involve the local community in making programmatic decisions—deciding what is done and how it is done.

Even when there is the will to involve local communities in decision-making, health staff often lack the skills and tools needed. There is still little attention given to developing tools for local-level health staff, who often work with limited technical and financial resources. Health staff need assistance in a number of areas, such as forming working groups with community representation, engaging in dialogue with communities, and planning interventions with and for the people most in need.

Objectives

The goal of the community assessment process described here is to enable the health staff and the communities they serve to jointly identify and prioritize health problems and to develop plans to solve them. The process collects and uses information on maternal and child health behaviors and is designed for district and subdistrict program planners and health staff. The important features of this process are as follows:

- As a "menu" to guide planning, it uses a limited number of maternal and child health behaviors that are critical to the prevention and management of the most important causes of childhood morbidity and mortality.

- It uses an integrated household survey to measure indicators of the key behaviors.

- It is conducted by a team of community volunteers together with the health staff, both of which are responsible for implementing health programs—not with an outside research team.

- It encourages community members and health staff to use and analyze information immediately to produce joint action plans.
- It collects data that can be used at multiple levels: at the community level to develop an action plan and at the district, zonal, and regional levels for project monitoring and evaluation.

Strategies and Implementation

Ministry of Health staff from the regional level, four zones, and five districts were trained in the methodology for one week. The group then broke into five teams and went to selected communities in these districts for 8–10 days, where the four phases of the assessment process were completed.

The process begins with a list of emphasis or key behaviors that have been shown scientifically to decrease child morbidity and mortality. The emphasis behaviors are used as a "menu" from which communities and health facilities jointly select, in order of priority, behaviors that are most important and amenable to change. These behaviors then form the basis for a joint action plan. The methodology combines participatory learning appraisal (PLA) methods with a structured household survey and is conducted over 8–10 days in each community. The four phases of the process used are as follows:

- *Phase 1: Identifying partners and building partnerships,* which emphasizes the establishment of working relationships between the health staff and community team members. The health staff are introduced to the community at large through a public meeting. Community members learn that the team is there to listen to them when they draw a map of their community and list their own health priorities.

- *Phase 2: Selecting the emphasis behaviors,* which involves the use of a simple household survey to collect information on key child health behaviors in a sample of households. The team then tabulates the data by hand. The behaviors shown by the survey to be at unacceptable levels are ranked by groups of men and women according to the importance of the behavior and the feasibility of changing it. On the basis of the community ranking, three to five priority behaviors are selected.

- *Phase 3: Exploring reasons for the behaviors,* which involves the use of a variety of participatory research techniques, including semistructured interviews, seasonal calendars, and matrix ranking, to explore the reasons behind the practices of the three to five selected behaviors. For each behavior, a list of suggested topics and methods for understanding the behavior more fully is used.

- *Phase 4: Developing intervention strategies,* which is based on the reasons why people are not doing the selected behaviors. The intervention strategies are suggested by community members and the health staff. During a public meeting, the action plan is developed for implementing the

strategies. The action plan includes the identification of resource needs and allocation of responsibilities.

Communities and health staff are encouraged to develop action plans that are feasible with existing resources and structures. In general, the activities focus on the household (the knowledge and behavior of caretakers), the broader community (supports required to sustain or bring about household behaviors such as the availability of soap or of community health workers), and the health facility (health worker knowledge and practice, the availability of medications).

The strategies developed by communities in Ethiopia had a number of similarities. Community members were often not able to get vaccination or antenatal services, so it was proposed that better integration of services would reduce missed opportunities for immunization and antenatal screening (e.g., checking the vaccination status of mothers and children during visits for curative care). Improving the counseling and health education skills of health workers on several key primary health care topics was considered very important. Within communities, improved community organization and participation were considered important for ensuring household behavior change. It was proposed that community-based health workers and community groups be encouraged to conduct health education and motivate community members to seek services. Most communities wanted to involve existing community groups such as churches, mosques, women's associations, and schools in health work. Some of the women said that sometimes their older children in school remind them to take their infants for immunizations. Some community members expressed a need to develop new groups such as health and nutrition groups.

The need to develop incentives for community health workers was raised in all communities and considered essential to sustaining their performance. Community groups discussed the development of revolving drug funds or central community funds for supporting community health workers, as well as other types of incentives such as regular training and the provision of farming assistance for workers and their families.

The implementation of the action plans began immediately, in some areas with the community driving the process. To date, health posts have been refurbished in some communities, community health agents (CHAs) have been selected and trained, water springs have been protected, and some vaccination outreach sessions have begun. During the next month, health education materials and activities will be developed.

Evaluation

The community planning process includes an integrated household survey that measures indicators on each of the emphasis behaviors. After a year of implementation, this household survey will be conducted again to evaluate the impact of the community action plans on selected caretaker behaviors.

Lessons Learned

It is important that the features and limitations of this process be clear (Table 1).

Table 1. Community Assessment and Planning Process

Does—	Does not—
< Teach health staff to learn and listen from community members	< Change existing power relationships within a community
< Give communities and health staff boundaries and a focus for the discussions (emphasis behaviors)	< Create sustained changes in the attitudes and behavior of health staff toward communities
< Use the emphasis behaviors as a way to open up discussions of constraints (cultural, social, environmental)	< Produce in-depth information on cultural belief systems on any of the behaviors
< Use data and community priorities to decide health activities	< Produce quantitative data that can be generalized beyond the communities where it is collected
< Begin a better relationship between health staff and communities	< Constitute a blueprint for better health planning

First, this approach is not intended to produce community participation or empowerment in a broad sense. During the process, an attempt was made to be aware of the existing power relationships in communities and to identify and involve the most vulnerable groups, but it is unlikely that this process alone will change those relationships. Second, this approach is unlikely to produce sustained changes in how health staff interact with community members; ongoing training and supervision will be necessary for this to occur. Third, since limited data are collected, this approach does not allow the investigation of the complex social and cultural aspects of each behavior. The data collected are intended to allow sound program decisions. Fourth, this process is not a blueprint or recipe for health planning.

The menu of behaviors, the specific methods used, and their sequence and timing (whether over 10 days as done here or over a longer period of time) must be modified and adapted to local situations. For example, there is no guarantee that drawing a social map and holding a public meeting will create rapport and generate a sense of partnership. The goals of each of the four phases (building partnerships, selecting behaviors, exploring reasons for the behaviors, and developing an action plan) are an overall guideline of key steps to follow.

This approach does represent a change in the way health planning is done at the local level. Currently, most program decisions are made without using local data and without any community involvement. The process teaches health staff some concrete skills for collecting and using data with community members. The use of emphasis behaviors worked well because maternal and child health issues were an important

priority in these communities, although not always the top one. Simple quantitative and participatory methods that can be implemented quickly with a minimum of resources make this approach more feasible for local health staff.

While the emphasis behaviors provided a focal point for planning, the suggestions for changing these behaviors were not limited to individual behavior change issues (such as health education for mothers) but also highlighted the need to change organization and support in the community itself and to improve the quality and accessibility of care available at health facilities. As a consequence, health staff were made aware of the impact of their own policies and practices on members of the community. In this way, this assessment and planning process can begin to change the relationship between health staff and community members.

Community-Based Mortality Surveillance in Bolivia

Presented by René Salgado, Technical Officer (ARI), BASICS Headquarters

Background

Most children in the developing world do not die simply of disease; the mixture of cultural, behavioral, social, and economic factors within the family, the community, and the health services that affects how disease is recognized and managed is also implicated. Yet despite the abundant literature on the effects of biological factors on child morbidity and mortality, there have been few studies in the developing world that seek to identify and quantify the socioeconomic and cultural processes leading up to a child's death. Such information would be invaluable for health planners and managers of health programs because it could provide an indication of where care-seeking or care-giving has broken down and where corrective action can be taken. Interventions can be more finely targeted and resources better used.

A BASICS study was conducted in El Alto, Bolivia in 1996 to attempt to identify causes of death of children under 5 years of age (U5s), including qualitative information on factors, other than biological, that might have affected care-seeking and care-giving practices. The study's community-based approach was designed around the Pathway to Survival, a conceptual framework developed by BASICS in collaboration with CDC and USAID, which assists in the development and monitoring of IMCI programs. The Pathway is a framework for understanding the care that children need to improve their chances for survival and summarizes the different "moments" or "steps" that might occur inside and outside the home when a child becomes ill (see Figure 1).

One of the principal difficulties in implementing a mortality surveillance project in situations where data on deaths are not easily available is the timely detection and reporting of deaths. In this study, most reports came from families and neighbors; often a grieving caretaker indicated where another death had occurred. This level of involvement was present throughout the study. In fact, the level of interest and discussion that was generated within the community and health services regarding the deaths of children might be considered an intervention in itself, since it raised the awareness and the willingness of caretakers and providers to do something to resolve the problem.

The death of a child is a critical event that can help marshal strengths and resources to solve problems at the community level. Community leaders cannot turn their backs on children; however, discussion often revolves around numbers and percentages—too abstract to have local impact. This study brought the issue of child deaths into a sharper, more personal focus through the community's participation in detecting deaths occurring in the neighborhood and through the sharing of narratives such as the open histories that usually began an interview and related, in the mother's own words, how the child died.

On the basis of the lessons learned from the study, BASICS is developing a manual for conducting this type of community-based surveillance that will have many potential benefits for district health program managers and planners. The step-by-step procedures for developing the mortality surveillance system with the participation of the community are briefly described here.

Developing the Surveillance System

After a health program decides to conduct a mortality survey and financial support has been secured at the national, district, or international level (the last is least likely), the program manager should hire a physician or high-level nurse with public health training as coordinator of the surveillance project. The professional status of the coordinator is important because this person will work closely with an advisory panel of health experts and also be responsible for training the supervisors and surveyors.

Three outside groups are needed to ensure project success; these groups help collect, analyze, interpret, and disseminate the data and use it to develop meaningful health interventions.

Coordinating Committee

This serves as a link to agencies and sectors other than health. It can include representatives from agencies such as the local government, the civil registry, the Education Ministry, interested professional societies, and the broadcast and print media. A police representative may also be helpful for reasons of security and clearance. The committee, chaired by the program manager, monitors project activities, reviews reports, disseminates findings, and assists in developing and implementing interventions.

Expert Panel

The project coordinator organizes and chairs this technical advisory group. It is best to have local and regional medical and health experts to serve on the panel; they may be from within or outside the health program. International agencies already working with the program can also be included. The panel's role is to help plan the project, review its objectives and indicators, review and help adapt data collection forms to local environment, help develop the analysis plan and analyze and interpret data, and help develop and evaluate interventions.

Community Partnership Group

This group is the project's link to the residents of the area served by the health program. Surveillance projects can be particularly effective in building a long-term, stable partnership with the community; however, they must seek input from the community. This group's role is to help determine the geographic

area for the survey, introduce surveyors to villages and neighborhoods and locate households with child deaths, help monitor the project, and assist with interpreting findings and developing interventions.

Input from the community will allow the program to better understand local health perceptions and needs and, consequently, develop more effective interventions. This group can also facilitate the active participation and motivation of child caretakers, which will be required for most interventions.

Forming and working with a partnership group may be a difficult task, but it is vital to developing meaningful interventions. The group should be organized early in the life of the project. Its membership should be sought among existing local organizations interested in health, such as mothers' clubs, health committees, block groups, labor cooperatives, and school and religious groups. Another important membership consideration is cultural, gender, and economic diversity, which allows resources to have the widest possible impact. The selection procedures for membership should be highly flexible; incentives such as honoraria may be appropriate in some areas. A system of feedback to the original groups is vital for ensuring a wider impact; a "group of groups" that reports back to individual groups may be a preferable arrangement for the sake of efficiency. The membership of the group will depend on the size and diversity of the community, but it should include from 10 to 20 community members and several surveyors and supervisors.

Orientation to the Pathway to Survival

At the outset, while seeking to enlist members for the partnership group, the program should inform the community that it is trying to improve the health of children in the community and needs its participation and help. This is an effective way to elicit the community's beliefs and insights about health and practices that promote or hinder it and relate them to the concepts embodied in the Pathway. Specific exercises for orienting the group to the Pathway include community mapping, illness role plays, and discussions.

The orientation should begin by having the people draw a map of their community, showing the households. The people should then be asked to indicate on the map households where children have died in the past year or so to focus attention on the *number of child deaths*. Next, the group should be encouraged to talk about the reasons for those deaths to focus attention on the *multiplicity of reasons for child deaths*. Finally, they should be asked to indicate all the places people go for health care, both traditional and allopathic, to focus attention on the *variety of resources for child health.* Once the group is ready, the lessons learned from these exercises should be placed within the context of the Pathway; since the Pathway shows how all the steps fit together, this would be an excellent way of setting the stage for selecting the most favorable steps for an intervention. The discussions should be guided to accomplish the following:

- Identify the steps in the Pathway where the care of children in the illness role plays broke down;
- Ascertain the reasons for the breakdowns;
- Clarify that desirable care may not be given by each type of provider (a sensitive point that needs to be handled with tact and sensitivity); and

- Clearly establish that the purpose of the project is to support the development and implementation of health program interventions.

The coordinator should inform the group that the data will be analyzed to identify the indicators of community health problems—where breakdowns in the Pathway occurred for actual illnesses—and that the group will be asked to help interpret the data, select problems for interventions, and develop and promote healthful message in the community. This sense of responsibility could be a powerful motivator.

Deaths in the Project Area

The deaths in an area can be located by conducting a census or by establishing a death-reporting network. In a surveillance system, deaths are investigated soon after they occur. The pace is slow and can be handled by community volunteers. A survey project must quickly locate recent deaths and interview the caretakers over a short time; this is easier to do with paid workers who conduct door-to-door census of all births and deaths.

Death-Reporting Network

The network should include all sites where child deaths might be noted. These can include civil registries, cemeteries, hospitals, physician associations, traditional practitioners, community organizations, and households, among others. The network is developed by the project coordinator, who asks each site to select a literate reporter. Surveyors and supervisors are the project's main link with the network. Reporters are provided with a form to record deaths of U2s, as well as pregnancies and births. Information on locating households where these deaths have occurred is also provided and, if possible, the households are marked on a map developed by the project. All reports should be cross-checked by the coordinator to prevent double counting and logistical problems.

Census

Census takers should begin work immediately, as the census must be completed by the time surveyors are fully trained. The census takers go house-to-house in the project area, recording all births in the past two years and any deaths of these children. A local events calendar can be useful in ascertaining approximate birth and death dates. The interview sample for the census is selected from the deaths that occurred in the past year. If the census is being done as a baseline study, it is helpful to also record pregnancies, which then can be tracked to identify neonatal and infant deaths. If a reporting network is established to assist the census takers, it should include most of the sites already discussed. Neighborhood reporters can help introduce census takers to the households and communities. The census data can be cross-checked with death reports from other sites.

Detailed information on this type of community-based surveillance system will be available in the near future in the BASICS manual mentioned earlier in this report.

Innovative PVO Community Approaches

Presented by Barton R. Burkhalter, Technical Officer (Operations Research, Nutrition, and Small Grants), BASICS Headquarters

Background

Private voluntary organizations (PVOs) have played a key role in the international child survival movement since its inception, working with dedication and creativity in remote and impoverished communities to bring about real changes for the better. Many innovative solutions have emerged from their committed efforts, especially through the child survival grants provided by USAID.

Three programs that highlight PVOs' community approaches are presented to demonstrate how they have been solving tough problems in new ways. In Malawi, Project HOPE's collaboration with large tea estate companies is providing primary health care to agricultural workers and their families. In the peri-urban areas of Guatemala City, volunteer breastfeeding counselors, initially trained by La Leche League and no longer supervised after the termination of the USAID grant, are still functioning to support mothers in the nurturing of their young children. In Haiti, a network of volunteer mothers is helping to link rural household to a district hospital through a community nutrition program. These programs provide some important lessons in cost-effectiveness, sustainability, scaling up, appropriate responses to given communities, and low health worker to population ratios.

Employer-Based Maternal and Child Health Model in Malawi

Background

The program began with 39 agricultural tea estates in southern Malawi deciding to extend preventive health care to the families of estate workers under a USAID grant to Project HOPE in 1990–91. Estate clinical services were providing curative care that was generally inadequate and available only to employees and their families. Overall, government health services were poor and inaccessible; no preventive care was available.

Objectives

The program would expand employer-provided clinical services on estate compounds to include long-term preventive care and improve curative care, thereby improving the health of the families.

Strategies and Implementation

Each estate agreed to hire a health promoter to provide maternal and child health care to all families living on estates and many off the estates in nearby villages. The promoters helped establish specialty clinics, build and maintain water and sewer systems, clean up residential compounds, and do other structural tasks as well as provide community education, immunizations, and other preventive measures.

The health promoters were supervised by Project HOPE in close cooperation with estate medical advisers.

Evaluation

In 1996, Project Hope undertook a study, funded by BASICS, to measure the extent of improvements in health practices and conditions and to ascertain the reasons for the estates' decision to join the program in the first place and then to continue it with their own funds. Results showed significant improvement in the health situation. Coverage for family planning, well-child care, and antenatal care improved dramatically—from 20 percent in 1990 to 55 percent in 1996. Satisfactory housing, water, and sanitation also increased, from 71 percent in 1990 to 88 percent in 1996. The same is true of household health practices such as exclusive breastfeeding (30 percent in 1994 to 48 percent in 1996) and nutrition. The study did not find any change in immunization coverage or other health practices.

Accomplishments and Lessons

The program improved the availability of specialty clinics, water and sanitary facilities, adequate housing, and numerous beneficial health practices, especially those related to nutrition and breastfeeding. The estates decided to continue funding the program with their own money after the USAID grant ended, and several additional estates asked to join up.

The primary reason for the estates' decision to join the program was that it would be good for the employees and families, would not cost much, and would not place additional burdens on management or cause disruption because Project HOPE was perceived as a competent health group. Return on investment was not a consideration.

At present, there are 58 estates, owned by 11 different companies, that have joined the program, providing preventive care to 55,000 workers and 275,000 family members (20 percent of the total population). A new local NGO has been established to take over the coordination and supervisory responsibilities assumed by Project HOPE under the grant, which ended in September 1997. The program is now fully funded by the estates themselves.

Grassroots Mother-to-Mother Support Model: La Leche League Guatemala

Background

In 1988, La Leche League International (LLLI) and La Leche League Guatemala (LLLG) initiated a project to establish a community network of mother-to-mother support in poor peri-urban areas of Guatemala City with funding from USAID. During the four-year grant period, 214 community volunteer mothers were trained and supervised as breastfeeding counselors (BCs), at a total cost of $190,000, to provide one-on-one counseling to other women in their area, refer them and their children to nearby clinics, and run support groups.

At the end of the grant in 1992, the counselors and the LLLG staff jointly decided to continue the program. The counselors elected one of their own from each neighborhood group as a coordinator to lead them and to represent them to the program. LLLG agreed to support the program by holding monthly meetings and miniworkshops for the coordinators, maintaining the information system, and providing

overall coordination with a reduced staff. These commitments have been maintained, although no new counselors have been trained.

Objectives

The project set out to establish groups of trained local mother volunteers to promote and support breastfeeding and other effective maternal and child health behaviors.

Strategies and Implementation

- LLLG staff and volunteers selected and trained volunteer mothers from poor neighborhoods.
- Once trained, the BCs organized and operated mother support groups and provided individual counseling and referrals for mothers and children to health facilities.
- The league did some fund-raising for the project, held monthly meetings for the elected coordinators, offered annual training workshops with all the volunteer counselors, and maintained liaison with LLLI to keep abreast of developments.
- None of the volunteers at any level received any pay for their work.

Evaluation

In 1996, LLLG undertook a study of coverage and sustainability funded by BASICS. The study obtained data from a household survey, structured interviews, and administrative and financial records maintained by LLLG. The data were use to ascertain the coverage of the program and to identify factors that might enhance program sustainability and productivity. The results were encouraging:

- Seven communities that had decided in 1992 to continue the program were still operating after four years.
- Most counselors are still functioning in their communities; however, fewer are running support groups.
- Twenty-five percent of the community women are in contact with a counselor.
- Eleven percent of the women are in support groups.
- Ninety percent of the women referred to clinics by the counselors actually went.
- LLLG's annual budget is $20,000.

Accomplishments and Lessons

This program achieved sustainability at low cost while maintaining effectiveness. Four years after the voluntary counselors were trained and the grant funding ended, nearly all of the counselors were still working effectively in the same communities. They were in contact with a substantial proportion of the women in these communities, promoting breastfeeding and referring mothers of sick children to clinics.

These results were achieved not by supervision in the traditional sense but by a combination of motivation and support, implemented by a six-layered structure that evolved in the course of the program. The volunteer counselors from each community elected coordinators from among themselves who worked with LLLG and provided leadership in their communities. LLLG, for its part, raised the funds needed and provided training and encouragement to the coordinators while receiving materials and support from LLLI. In the communities, the volunteer counselors gave support to the mothers in the support groups; these mothers in turned counseled other women in the community—the so-called "ripple effect."

Hearth Model: Haiti, Vietnam, and Bangladesh

Background

The Hearth Nutrition Model has evolved in Haiti and other countries over four decades. The model is designed to combat childhood malnutrition by feeding malnourished children while educating and motivating their mothers. The basic program approach is to arrange for volunteer community mothers to feed malnourished children a single nutritious morning meal each day for two weeks. The children are dewormed before the feeding sessions begin. The program is implemented in a context of generalized poverty and through a district-level health facility.

Objectives

- Reduce child malnutrition.
- Establish a district-wide network of volunteers linked to the health facility that can provide broad health and social promotive services to families, especially to mothers.

Strategies and Implementation

The program was implemented in Haiti through Hôpital Albert Schweitzer, a private district hospital; in Vietnam through the government and included women's organizations at the community level and Save the Children Foundation; and in Bangladesh through the Christian Service Society and the World Relief Corporation. Typically, nutrition educators identify and train volunteer mothers and then motivate them through a feeding program that dramatically rehabilitates malnourished children in two weeks.

The feeding program uses local, affordable foods and menus "discovered" through mothers of well-nourished children in the community, thereby convincing other mothers that they too can rehabilitate their malnourished children by adopting these "positive-deviant" feeding practices. The volunteer mothers then prepare and serve food each morning to two to six malnourished children from families they have selected themselves to work with.

The feeding program is often integrated with other nutrition and health interventions such as deworming, growth monitoring, referral to health facility for underlying illness, and micronutritient supplementation. Other programs such as credit for microenterprise, job creation, breastfeeding, and family planning are

introduced through the volunteers after the nutrition program succeeds. The programs are all transparent to the community, so that mothers learn through self-discovery rather than being taught directly.

Evaluation

Studies have been completed in all three countries with significant positive results, especially in Vietnam, where severe malnutrition was eliminated dramatically and sustainably. Haiti showed good results in rehabilitating mild to moderately malnourished children. The program in Bangladesh is relatively new and, although the results are encouraging, further studies are needed for more definitive results.

Accomplishments and Lessons

- The program has reduced malnutrition: In Vietnam, severe malnutrition was eliminated in preschool children; in Haiti, mild to moderate but not severe malnutrition was significantly reduced in program participants relative to a comparison growth monitoring and promotion (GMP) group one year later; and early results from Bangladesh also show success.

- The program can be scaled to the district level and beyond. In Vietnam, the program will soon reach communities with a combined population of about 1 million, and the government intends to implement it nationwide. In Haiti, about 1,900 volunteers are active in the district, promoting a variety of public health programs.

- The program is reasonably inexpensive—about $7 per participant in Haiti—and is carried out primarily by local mothers rather than professionals. Low cost and minimum requirements for professional personnel are keys to achieving scale-up.

- Effective linkage with district institutions supports dynamism and sustainability.

- Positive deviance is an effective way to achieve credibility for the program.

- Nutrition rehabilitation, which can be accomplished in the relatively short period of two weeks, is dramatic in transforming listless, apathetic children into active, alert children, a result that is highly motivating to mothers.

Numerous PVOs are interested in pursuing the Hearth model in their community-based programs.

Slum Strategy in Bangladesh

Presented by Iqbal Hussain, BASICS/Bangladesh Staff Member

Background

The population of Bangladesh is estimated to be 120 million, 23 percent of whom live in urban areas. Cities and municipalities are growing at an annual rate of 6 percent, three times faster than the country as a whole, as more and more extremely poor, landless rural people migrate to the cities to find work. The result is a mushrooming of squalid slums and squatter settlements. The slums may be privately owned or built illegally on any abandoned government land and vary in size from a few dwellings to several hundred. The dwellings, generally constructed of mud and thatch, are seldom more than one small room for four to five people. The absence of running water, sanitary latrines, and even a rudimentary waste disposal system is universal. Such overcrowded, unsanitary, and substandard living conditions, combined with the abysmal nutrition status of this population, puts it at high risk of communicable diseases.

The majority of slum dwellers are illiterate and work at low-paid jobs, leaving them with little time and energy for anything other than the grind of daily survival. The infant mortality rate (IMR) in the slums is more than double that of the national average. Acute respiratory infection (ARI), diarrhea, malnutrition, measles, and neonatal tetanus are the common causes of childhood morbidity and mortality.

The responsibility for providing health services in urban areas lies with city corporations and municipal authorities, which are beleaguered by endemic shortages of resources. The slack is taken up, in practice, by a range of private traditional healers, qualified personnel, NGOs, and Ministry of Health and Family Welfare facilities. However, the slum populations' access to public or private health services is severely limited.

Despite the overall success of the national Expanded Program on Immunization (EPI), there is overwhelming evidence that coverage is lagging behind in the slums—5 percent to 15 percent lower than in other areas. The absence of televisions and limited access to other mass communication media prevent most health education and awareness programs from reaching this population; interpersonal communication remains the most important source of health information for them.

The slum strategy was driven by the Government of Bangladesh's commitment to achieving and maintaining 85 percent immunization coverage for all antigens. Over the past decade or more, the government has effectively increased the supply of and demand for health care services through the provision of vertical programs such as EPI, ARI, control of diarrheal disease, and family planning. However, the ability to sustain the provision of primary health care services through parallel vertical programs has been less than optimal. Therefore, it is now believed that a more sustainable and cost-effective approach to the delivery of primary health care services would be through an integrated package of basic services, which would include EPI, maternal and child health, and family planning.

Objectives

BASICS is collaborating with the national EPI project to implement a strategy to improve immunization coverage by increasing and sustaining demand among the slum population in the short term and to include immunization within a package of primary health care services in the longer term. The project was initiated as a communication intervention to change the behavior of slum inhabitants in utilizing immunization services in particular and child health services in general.

Implementation

The project began with the selection of 10 cities. In large cities such as Dhaka and Chittagong, one or two zones were selected rather than the entire city. The selection criteria included (1) a large concentration of slum dwellers, (2) a substantial gap in immunization coverage between slums and other areas, and (3) the availability of service providers—for example, NGOs.

Situation Analysis

Knowledge, attitude, and practice surveys as well as informal discussions were conducted with the target populations to ascertain the reasons for their failure to utilize the EPI services. Barriers to utilization were also explored. Aside from the obvious reason that mere subsistence was a primary time consumer for most people, a lack of information about the importance of immunization in safeguarding the health of their children and about doses and frequency of vaccinations made it a low priority for most of them. Distance and transportation costs involved in getting to an immunization center also acted as barriers.

Mapping and Inventory of Services

The selected sites were mapped for total number and location of public and private facilities to ascertain the slum population's access to immunization services. The information was then used to add additional centers or rearrange the location of existing ones. Alternative service delivery facilities such as mobile teams and evening sessions were also instituted.

Communication Model

There are three main components in the model used:

Advocacy. Various interpersonal and mass media channels, such as public meetings, rallies, seminars, televison, radio, and newspapers, were used to enlist the support of decision-makers and community leaders.

Mobilization. The decision-makers and community leaders were involved in mobilizing intersectorial allies to propagate the program.

Communication. The program was taken to the communities by targeting specific groups and audiences with specific messages or training programs through various interpersonal or mass media channels.

Accomplishments

- Local leaders were successfully involved as primary advocates for mobilizing the community.
- Alliances were built with NGOs, schools, social and civic clubs, and rickshaw pullers' associations.
- Mapping and inventory of services were completed, and as a result of the consequent adjustments, the target communities' access to immunization centers was improved.
- The use of various channels for program communication was effective in reaching the target audience.
- Linkages with NGOs and donors have been established to achieve the long-term objective of the project.

Lessons Learned

Involving local leaders as program advocates is the best method for building alliances.

- Interpersonal communication is the best means of getting the message across to the communities.
- Mapping and service inventory are useful tools for ascertaining the target population's access to health care facilities.
- The long-term goal of providing integrated primary health care services to the community requires effective linkages with NGOs and donors.
- Affecting behavior change among the slum population to improve utilization of immunization is not an easy task.

Community Monitoring of Private Providers in India: Results from an Operations Research Study

Presented by Sarbani Chakraborty, Consultant for BASICS/India

Background

Since independence in 1947, India has made substantial progress in improving child survival. Despite these gains, the burden of disease from childhood illnesses remains high. For example, of India's total burden of disease of 292 million disability adjusted life years (DALYs), 49 percent is attributable to morbidity and mortality among children 0 to 4 years old, according to a 1995 World Bank report. Thus, India has a huge unfinished agenda for child survival. The achievement of child survival goals is constrained by several factors, most importantly an ineffective government health system marked by poor access and quality, a stagnant health budget, and the large-scale emergence of new diseases such as AIDS. To achieve child survival goals in this environment, strategies that optimally utilize limited resources will have to be developed.

Given the weaknesses of the government health system, it is no surprise that most Indians turn to the private sector for their health needs. It is estimated that more than 80 percent of households in urban and rural India use private practitioners for childhood illnesses. Therefore, instead of expanding government health services, an alternative approach is to guarantee that the care provided by these practitioners contributes to child health. In the private sector, quality of care is of particular concern. Since quality of care, especially technical quality (the appropriateness of processes used to diagnose and treat diseases), is linked to improvement in health outcomes, it would be appropriate to work with the private providers on this issue. A combination of training and monitoring is considered essential for improving technical quality. A sustainable and cost-effective approach to monitoring would be through the community. This strategy would also comply with India's recent efforts to strengthen decentralization and empower community groups, especially women's organizations (*mahila mandals*).

Objective

The objective of the study was to improve the case management practices for ARI, diarrhea, and fever among unlicensed private providers through community-based interventions. This group of practitioners was selected because they provide the bulk of curative services for childhood illnesses in rural areas and urban slums where infant and child morbidity and mortality rates are high. It was anticipated that improvement of case management practices would, in the long term, contribute to improvements in child health. This objective was to be achieved through the implementation of four interventions: (1) information/orientation sessions for providers on correct case management practices for ARI, diarrhea, and fever; (2) an agreement or contract to practice the behaviors, signed by the private practitioners and the community, which was defined as the immediate beneficiaries of services provided by the practitioners; (3) community-based monitoring of provider compliance with the contracts; and (4) building village health committees and strengthening women's organizations.

Study Area

The study was implemented in two rural subdistricts of Bihar (Dumka and Bettiah). The total population of the 110 villages included in the study is approximately 54,000. Fifteen percent of the population consists of children under 5 years old. The majority of the population belongs to minority groups (scheduled caste and scheduled tribes). Illiteracy rates, especially among women, are very high, and the average household lives at or below the poverty line. Infant and child mortality rates are higher in the two districts than in the

rest of Bihar, which has the third highest infant mortality rate in India. All 70 practitioners who provide health services in the 110 villages were included in the study.

Implementation

The study was implemented by three Bihar-based NGOs with technical assistance from BASICS (see Table 2). One of the NGOs was a support-service organization and provided assistance to two field-based NGOs that were directly responsible for implementing the interventions.

Table 2. Implementation Teams: Nature, Size, and Functions

Implementation Team	Size	Functions
Kurji Holy Family Hospital—service support organization based at the state level	4 persons	Work with local NGOs on all aspects of planning, implementation, and evaluation of the interventions; liaise with technical assistance team
SPAA—community-based NGO with 10 years of experience in implementing social development projects	12 persons (including 10 community health workers)	Plan, implement, monitor, and evaluate the interventions
ADHAR—community-based NGO with 5 years of experience in community development	Same as for SPAA	Same as for SPAA
BASICS—international child survival project	2 persons	Technical assistance on all aspects of the study to support service organization and, indirectly, the local NGOs; conduct process evaluation

Step-by-Step Strategy

The implementation strategy was as follows:

- Step 1: Organize information and orientation sessions for providers on correct case management practices for ARI, diarrhea, and fever.
- Step 2: Organize village health committees and strengthen women's organizations (implemented throughout the duration of the study).
- Step 3: Decide behaviors to be targeted through the contracts (joint decision by village health committees, CHWs, the NGOs, and BASICS).
- Step 4: CHWs, as representatives of the community, visit providers to sign the contracts.

- Step 5: CHWs monitor provider compliance by interviewing mothers during bimonthly meetings of women's organizations using the verbal case review (VCR).
- Step 6: CHWs analyze provider performance by matching monitoring information with provider contracts.
- Step 7: The health workers return to the providers with the information; the village health committees and women's organizations are also informed of provider performance.

We were able to complete most of the implementation steps entailed by the study. Significant positive improvements were observed in providers' disease-specific and other case management practices. Additionally, as a result of the interventions, the providers began to participate in community health education activities. Several providers attended health workers' meetings to discuss collaborative strategies for improving community health.

The success of the study can be attributed mostly to the CHWs, who were highly motivated, understood the importance of correct case management, and worked hard to ensure that the providers adhered to these behaviors. The providers respected the CHWs and their knowledge of health and were willing to cooperate with them. The only performance gap was in forming the village health committees and strengthening women's organizations; as a result, the goal of community monitoring by mothers and other members of the community was not fulfilled. However, the lessons learned from this performance gap are important for any future replication of the study.

Evaluation

The evaluation strategy focused on process and outcomes. First, baseline data on providers' case management practices prior to the interventions were collected; 11 months later, a final evaluation was conducted. The baseline and final evaluation used VCR to obtain information for quantitative analysis of study outcomes. Additionally, focus and key informant interviews were conducted to supplement the information from the VCR. The process evaluation mainly focused on evaluating the implementation of the interventions, using individual, key informant, and focus group interviews to obtain the data. The process evaluation is the main source of information regarding the dynamics of community involvement in the implementation of the interventions.

Lessons Learned

Village Health Committees

One objective of the study was to organize village health committees. Building new community-based organizations is a complex task, made even more difficult when sustainability of these groups is a goal. Twelve months was perhaps too short a time to implement the training and monitoring interventions and to

organize new community groups. Future efforts to replicate the study should take this fact into account and allocate adequate time for this activity.

Women's Organizations

Limited participation by the women's organizations was related to several factors. At the time the study was implemented, the mothers were unaware of quality of care issues and their relationship to child health; generating demand within the community for quality care might have helped to elicit greater participation from the women's groups. The relationship between the providers and their clients was also an issue, some mothers in the community expressing concern about monitoring the providers. Several mothers said, with great respect and reverence, "The doctors are like gods for us and without them our children would die." With this mind-set, it may be difficult to convince the mother that some of the doctor's practices are harmful and should be changed. In fact, in future replications, an effort should be made to determine how community perceptions may or may not affect community monitoring of providers.

In conclusion, the Bihar study demonstrates that it is possible to bring about changes in the case management practices of providers through community-based monitoring. However, the study also underscored the complexity involved in using a community participation approach and showed that it requires attention to the issues being targeted, focus on community perceptions and attitudes, and allocation of sufficient time for institution building and strengthening.

Chapter 3
Implementation, Monitoring and Evaluation, and
Scaling Up: Group Discussions

Workshop participants were divided into three discussion subgroups, as follows: subgroup 1, implementation; subgroup 2, monitoring and evaluation; subgroup 3, scaling up.

Implementation I: Planning

In reviewing and synthesizing BASICS's experience to date, the subgroup identified five components of successful community program planning.

1. Coordination with Existing Programs

Insofar as possible, BASICS has cooperated with the other programs in an area to avoid overwhelming local systems with redundant or competing information and activities. Effort has been made to build on existing child health programs and to establish liaison with related health programs such as maternal health and family planning. By acknowledging planning and funding constraints and limitations and coordinating program activities among themselves, donors, cooperating agencies, and implementers can enhance program outcomes.

A key first step for a project like BASICS is to inventory programs being implemented by the Ministry of Health and other ministries in the target locale as well as by PVOs, NGOs, and CBOs within the country. BASICS must also assess the commitment of the national government, international donors, and USAID to supporting community-level activity.

2. Involvement of Stakeholders (Including the Community)

The subgroup suggested the use of a matrix to analyze the stakeholders' involvement in the decisions leading to the establishment of a community-based program strategy (Figure 2). Questions that need to be resolved are (1) What is the function of each stakeholder? (2) What is each stakeholder's role and specific responsibilities? (3) What resources must that stakeholder bring to the table for the intervention to succeed?

Stakeholders on the matrix include MOH, USAID, BASICS, the community, other donors, and the private sector. Key questions include the following:

- Where will the program activities take place?
- What type of program interventions will be supported?
- With whom will BASICS work?
- Which population will be targeted?

In BASICS's experience, the nature of the interventions is often predetermined by agreements between the MOH and USAID. The MOH is the conduit to the community in all of the countries where BASICS is working, except Nigeria and Haiti.

Figure 2.
Sample Matrix for Stakeholder Analysis

Decision-maker	Where?	What?	With Whom?	To Which Population?	How?
MOH					
USAID					
BASICS					
Community					
Other donors					
Private sector					

Planners must clearly identify the objectives of involving the community, how community involvement will help reach the child health goals of its program, and how these objectives will be measured. Program planners also need to target a desired level of community involvement and, working with the community, map out the form that involvement will take. For example, the community may participate directly in program planning and local survey work (Zambia, Ethiopia) or may be involved more at the implementation phase (Honduras, Madagascar, Bangladesh). The Zambians took community participation in goal-setting to a new level by deciding to exclude BASICS staff from that meeting.

3. Technical Analysis

BASICS has conducted a variety of research activities with varying levels of community involvement to obtain the data necessary to plan, implement, and monitor and evaluate its programs. Researchers gather existing data and identify specific health problems that need to be addressed. The research can take many forms: health facilities assessments, community situation analyses organized in collaboration with local health staff, community demand studies, household surveys, mortality surveillance, community mapping and other participatory rural appraisal (PRA) exercises, and inventories of health providers.

4. Assessment of the Feasibility of Implementation

This component is also referred to as "needs assessment." The community lists the potential barriers to implementation of each intervention, the likelihood of encountering particular barriers, the resources required to overcome them, and the chances of success. It is important that the intervention(s) selected be pertinent, actionable, and modest. An early success can build confidence in the community participants and encourage them to try more challenging interventions.

5. Flexible, Iterative Planning

Community-based program planning is an iterative process involving many stakeholders with agendas that sometimes overlap and sometimes compete. USAID, BASICS, and any other organization or agency planning to work at the community level must allow sufficient time and resources to negotiate both the program strategies and the implementation of the programs that depend on community participation for their results. Every aspect of such a program depends on the collaboration of multiple stakeholders; the

key stakeholders, namely the communities themselves, may not have all the necessary knowledge and skills, at least at the outset, for quick and easy success. Developing community-based programs is a long-term investment requiring patience, flexibility, and vision.

Implementation II: Community Involvement

Drawing on BASICS experience over the past four years, the subgroup participants highlighted several successful approaches that have resulted in effective community participation in the country programs represented at the workshop.

1. Facilitate Community Participation in Selecting Program Goals

Participation may take a variety of forms. The community may participate directly in program planning and local survey work (Nigeria, Zambia) or be involved more in the implementation phase (Honduras, Bangladesh). One hybrid planning process discussed by the subgroup was the use of a menu approach (Ethiopia, Zambia; the latter has modified this initial approach to accommodate greater community involvement in the process). BASICS can clearly lay out what it may fund as a menu of technical assistance and support and the communities, having identified specific health concerns, can then select from it according to its priorities. AIN used more of a curriculum approach, where CBOs were asked to participate in a certain core curriculum—growth monitoring—to which a variety of electives could be added. While BASICS can only support child health interventions, the community may apply the planning skills it acquires during the participatory process far more broadly. In Nigeria, where BASICS is prohibited from working with the government, community-based groups such as trade organizations and local health care providers participated in fora to identify needs and develop joint plans of action.

2. Make the Community a Partner in Health Sector Reform

Even the best planned community program cannot achieve long-term success without the support of the national government. Support at the national level helps to create an environment conducive to community participation and to behavior change. A favorable national policy environment can reinforce grassroots movements and encourage other stakeholders to take action on public health issues. Fortunately, many of the governments working with BASICS acknowledge the importance of grassroots involvement in program design and implementation. Where community participation is not already within the strategy of the national health sector policy, it is BASICS's role to advocate its inclusion.

3. Foster Community's Sense of Ownership

The most effective programs are those that have the most active participation from program beneficiaries. This does not necessarily mean that the programs have to originate at the grassroots level. AIN in Honduras was initially an international effort to use growth monitoring as a tool to identify children at risk. This simple concept was readily understood and accepted at the community level, and AIN was able to organize the communities rapidly and almost spontaneously to conduct the core activity of monthly growth monitoring meetings while customizing local details of group activities and organization. The key to the implementation of AIN is that this core activity is pertinent, actionable at the community level, and modest.

4. Foster NGO and MOH Interaction

A recurring issue in development programs is distrust between national governments and NGOs operating within their borders. The governments cannot easily control NGO activities; consequently, there is a potential for duplication of effort and conflicting messages. More often than not, NGOs have resources, community support, and access to international donor support, which may not be available to the government. NGOs can program with more local specificity, customize more easily, and be more flexible than governments can afford to be. It is BASICS's approach to facilitate a dialogue between government counterparts and the NGOs through whom it hopes to implement child survival activities. This may involve specifying the responsibilities of NGOs to government planners and of the planners to NGO implementers as well as defining the roles of the stakeholders at the outset of the implementation. To foster positive interaction, all stakeholders must establish realistic expectations of each other.

In Zambia, the communities solicited and reviewed proposals from the NGOs for the implementation of child health activities that had been identified and negotiated between the communities and the MOH.

5. Form Alliances and Partnerships

A number of projects have tried to form alliances in the field to accomplish their goals—alliances among, for example, BASICS, PVOs/NGOs, the private sector, community-based organizations, district- and community-level health centers, and donors. Because of its national and international links, BASICS is in a good position to facilitate alliances of public and private organizations at various levels to assess needs and provide services at the community level. For example, BASICS/Nigeria was able to serve as a catalyst in encouraging the private sector and community-based organizations to collaborate in improving private sector services and increasing demand. BASICS's role has been to help form community health partnerships, which then took it upon themselves to mobilize, develop formal organizations, draw action plans, and implement activities.

In Madagascar, local organizations—health as well as social, religious, and school groups—were tapped for coaches (nurses, teachers, agricultural workers, etc.), who were then trained to incorporate the use of counseling cards in their professional work. They are also providing guidance to village animation committees who have been trained in the techniques of staging and performing health promotion skits. In Bangladesh, local leaders are being used to advocate good health.

6. Foster Health System Collaboration with Other Sectors

BASICS can increase the likelihood of sustainability at the community level by facilitating cross-sectoral collaborations in community programs. BASICS/Madagascar has used this approach to advantage in developing with the Ministry of Education a child-to-child program at the national level. A curriculum is being developed that will be used by primary school teachers to involve their pupils at the community level in health education activities. (This approach would not be cost-effective, however, in countries where only some 20 percent of the children attend school, since the community effect would be much smaller.) A spring-capping project in Ethiopia was carried out successfully in collaboration with the water and sanitation sector.

Collaboration also depends on a good relationship between the Health Ministry and the other related ministries involved. If people at the top do not see the value of such collaboration, the work at the community level may die on the vine for lack of nourishment. The value of working with other sectors at the community level, however, is its multiplier effect and the shared sense of responsibility it engenders among others in the community. Schoolteachers generally do not feel particularly responsible for educating the adults in the families of their young charges. Exceptions do occur, however; schoolteachers in Ethiopia are making a significant contribution to adult health education. Such a collaboration between the fields of education and health can lead teachers to think of themselves as leaders in the development of healthier communities, not just instructors of children.

7. Build Incrementally and Use a Single-Focus Intervention as an Entree for Other Health Interventions

AIN, which launched a growth monitoring and promotion (GMP) project in several pilot areas in 1991, is now a national program. The quick initial success of AIN led to rapid expansion, leading to demand for participation from more communities, which may be indicative of communities' sense of ownership—an essential element in sustaining programs in the long term. The community participation component has worked to help parents of U2s to understand the importance of monitoring their children's weight gain and to adopt more nutritious feeding practices. Each project community is now collectively engaged in GMP activities to safeguard the health of its children. The Hearth program in Haiti has similarly involved its network of volunteer mothers, who started by rehabilitating malnourished children in their neighborhoods and assisting with breastfeeding promotion and AIDS and sexually transmitted disease (STD) prevention.

8. Use Incentives to Ensure Retention and Enthusiasm of Community Workers

Whether to reduce turnover, provide opportunities for learning, create competition, or instill a sense of ownership and pride, incentives do work. Madagascar, with "health festivals" and diplomas for mothers who complete the vaccination series before their child's first birthday; Zambia, with its very public process by which communities elicit proposals from NGOs; and La Leche League Guatemala, with its refresher training, annual workshops, and support for volunteer breastfeeding counselors, have all been able to maintain the community's interest in their projects. In the La Leche League Guatemala program, volunteer mothers continue to provide counseling and referrals even four years after the end of the grant. In the Hearth program, the incentive for volunteers, mothers, and neighbors can be the transformation in two weeks of listless, apathetic children who do not want to eat into energetic children who seemingly cannot get enough to eat. Visible success is a powerful motivator.

An overview of some specific strategies being implemented by BASICS to increase community participation in its programs is presented in Table 3. The list is not exhaustive, but it illustrates the range of strategies being undertaken at the community level.

Table 3. Community Involvement Strategies in BASICS Country Programs

Strategy	Country Programs	Description	Tools & Methods
1. Democracy and governance training	Nigeria	Communities are empowered to identify and solve problems.	Training, including mock parliament
2. NGO partnership grants	Zambia	District presents health problems in a public community forum and NGOs are asked to compete for grants to assist service provision.	Standardized NGO proposal forms and selection criteria; capacity building of NGOs
3. Community health workers	Zambia Ethiopia India	Community-based CHWs, TBAs, and CBDs are trained. CHAs are selected and trained. CHWs, as community representatives, visit providers to sign contracts for improved case management of ARI, diarrhea, and fever; monitor compliance; performance analysis.	Training curricula; flip charts and other CHW teaching aids
4.Child-to-child/ school-to-community	Madagascar Ethiopia	Curriculum for schoolchildren on target behaviors: (1) to bring up a generation of health-aware people; (2) to spread the word via children to rest of community. Small group education sessions using community volunteers, including schoolteachers, are held.	Peer education; games, stories, experiential learning activities; activities to engage children in educating the rest of the community
5. Participatory appraisal and planning	Ethiopia, Zambia, Honduras	Communities share responsibility for social mapping, data collection, analysis, and developing action plans.	Use of PRA, RAP, and anthropological techniques
6.Community role models	Madagascar	Community members who are practicing target behaviors are identified and invited to form network of role models and community resources for other parents: Amis de Santé.	Peers educate peers in the community
7. Community volunteers	Haiti Guatemala	Volunteer mothers prepare positive deviant menus and feed malnourished children. Volunteer mothers are trained as breastfeeding counselors to run mother-to-mother support groups, offer individual counseling and referrals.	Positive deviance to discover local affordable foods; adult learning principles

Table 3. Community Involvement Strategies in BASICS Country Programs (cont'd.)

Strategy	Country Programs	Description	Tools & Methods
8. Folk channels of communication	Madagascar Bangladesh	Village committees are given health messages and suggested role play; players develop skits around the messages and perform in the community. Volunteers use traditional folk performances in immunization drive.	Health skits; pictorial counseling cards provide themes for skits Folk drama and songs
9. Cross-sectoral alliances	Madagascar Ethiopia Zambia	Village-level coaches are recruited from agriculture, health, education, etc., to train and coordinate animation committees. Spring capping carried out with collaboration from water department. Partnership with an agricultural organization to support growing of groundnuts.	 Shared responsibility for problem-solving
10. Partnerships between private sector and CBOs	Nigeria	Private sector facilities and CBOs form CPHs and draw up MOUs for roles and responsibilities.	Private sector inventory, community fora, MOUs
11. Microenterprise projects	Nigeria, Zambia	Projects such as poultry farming, brick-making, mosquito nets, etc., are designed and managed by the community.	Meeting to assess needs; community bank account
12. Village health or animation committees	Ethiopia, Madagascar, Zambia	Well-functioning community groups or representatives from existing groups form link between district and community.	Village consensus on who will represent it in health matters; use of existing groups may increase group's status and strength and ensure credibility
13. Two-way referral of mothers—between health center and community	Honduras	Collaboration between health center staff and community volunteers to follow up on mother after she has left health center.	Adaptation of health center protocol
14. Political support	Bangladesh	Advocacy is used to involve local leaders (ward commissioners, mayors, etc.) in getting the immunization message out.	Direct appeal.

15. Collaboration with private sector employers	Malawi (Project HOPE)	Collaboration to expand clinical services to include preventive care for estate employees and families. Each estate hires a health promoter to provide health education, establish specialty clinics, and improve infrastructure.	Group health talk, mobilization of community around water, sanitation, etc.

Table 3. Community Involvement Strategies in BASICS Country Programs (cont'd.)

Strategy	Country Programs	Description	Tools & Methods
16. Community-based monitoring of provider compliance	India	CHWs collect information from mothers through women's organizations.	Prior qualitative research including VCRs, key informant interviews, and focus groups
17. Community health festivals	Madagascar	Festivals are held every six months to gather neighboring communities to create competition around theater and other activities.	Prizes for best theater and most active committee
18. Empowerment of women	Nigeria, India	Strengthening women's organizations through income-generating activities; interviewing individuals regarding case management by providers, and reporting findings to the group.	Income-generating activities; information feedback

Monitoring and Evaluation

Subgroup 2 discussed the purposes of monitoring and evaluation (M&E) in relation to different audiences, different programs and indicators, and different approaches and tools as well as costs. After the topic was introduced, the deliberations and conclusions of the subgroup were presented in a series of tables.

Purpose and Uses of M&E

Monitoring provides feedback to the community. It helps identify problems and their solutions to improve programs. The information is also necessary to secure, maintain, and distribute local resources and to motivate staff and communities. Community programs need M&E to fulfill contractual requirements, as protection against misuse of resources (real or perceived), and to comply with quality standards. M&E data should be used to determine whether program interventions are improving health outcomes in communities, and they can then be used to develop and modify interventions over time. Interventions whose effectiveness has been demonstrated are more likely to be appropriate for wider use in communities within the same country or in other countries.

M&E data that demonstrate program effectiveness are also critical for securing political commitment and resources (financial, human, and material) for primary health care programs at all levels.

Allocating M&E Resources

The question of balance arises in planning any M&E system: Where is the emphasis to be placed and how much is spent in providing information for different audiences? The subgroup believes that the amount of resources allocated to M&E depends on the type of information and the audience that uses it. One approach suggested by the subgroup is illustrated in Table 7, which is organized by the same types of indicators and audiences of users as in Tables 4–6. In Table 7, the bottom row is completed first, and the

total for each audience is allocated among the various types of indicators. Planners should note that the costs of an M&E system include planning, data gathering, data analysis, writing of report(s), and dissemination. Therefore, careful targeting of key audiences to keep costs and complexity at reasonable levels is important.

Table 4. Purpose and Uses of M&E, by Type of Indicator and Audience

Type of Indicator	Purpose by Audience—			
	Community	**Local Managers**	**Regional/National**	**Donors**
Impact, cost-effectiveness	A	A	C, E	B, C, E
Behaviors (individual and community)	A	A	C, E	B, C, E
Access, quality	A, E	A	B, C	C
Process (e.g., planning, training, systems improvement)	A, D	A, B, D	B, C	B, C, D
Inputs (e.g., money, workers, clinics, technology, materials)		A, B	B, C	B, C
Sustainability		A	A, C, E	C, E
Equity (e.g., gender, locale)	A	A	B, C, E	B, C, E

Key to types of purpose: A = monitoring for local feedback, B = audit or reporting, C = validation for continuation or expansion, D = validation for replication, E = advocacy.

Table 5. Types of Child Survival Indicators, by Audience

Type of Indicator	Indicator by Audience—			
	Community	**Local Managers**	**Regional/National**	**Donors**
Impact, cost-effectiveness	Vital events (e.g, community surveillance, verbal autopsy)	Trends in early child mortality	IMR, nutrition status (long-term)	IMR, nutrition status (long-term), cost-effectiveness
Behaviors (individual and community)	Measles immunization by 12 months of age	Children receiving vitamin A every 6 months	Fully immunized children by first birthday	Exclusive breastfeeding 0–3 months
Access, quality		Percentage of communities with at least one support visit each month per the protocol	Caretaker correctly counseled on return follow-up visit, percentage of facilities with functioning cold chain	Percentage of caretakers seeking care from trained providers
Process (e.g., planning, training, systems improvement)	Children with regular growth monitoring, percentage of women with at least one ANC visit	Support schedule available to all community health committees	Communities with "health friends" seeing 30 children	Communities with functional participation in health promotion
Inputs (e.g., money, workers, clinics, technology, materials)	Volunteers supported by community, new health friend recruited	Recurrent costs recovered from beneficiaries	Number of health workers trained in certain technique	Cost analysis for community partnership with funding percentage by donor–overhead–community
Sustainability	Nutrition counseling for caretakers of high-risk children			National budget for vaccines, gender differences in nutritional status
Equity (e.g., gender, locale)				

Table 6. Examples of Data Sources, by Type of Indicator and Audience

Type of Indicator	Data Source by Audience—			
	Community	**Local Managers**	**Regional/National**	**Donors**
Impact, cost-effectiveness	Community surveillance	Preceding birth technique	DHS household surveys	DHS household surveys, cost-effectiveness
Behaviors (individual and community)	Local area monitoring	Local area monitoring, LQAS	DHS household surveys, EPI cluster sampling	DHS household surveys
Access, quality	Local area monitoring	Supervision tool	Exit interviews, HIS for functioning of cold chain equipment	DHS household surveys
Process (e.g., planning, training, systems improvement)	Local area monitoring	Supervisory system	Special program review, lessons learned	Special program review or routine monitoring
Inputs (e.g., money, workers, clinics, technology, materials)	Local area monitoring (health committee registry)	Local area monitoring	Training database, supervision or support system	Financial monitoring by programs
Sustainability				DHS household surveys, special program review
Equity (e.g., gender, locale)				

Table 7. Estimate of Percentage Costs, by Indicator Category and by Audience

Indicator Category	Percentage Cost by Audience—				
	Community Levels	Local Managers	Regional/ National	Donors and International Agencies	Total
Impact	8	3	7	7	25
Behavior change	8	3	7	7	25
Outputs	4	4			8
Process		10			10
Inputs	4	4			8
Sustainability	3	3	3	3	12
Equity	3	3	3	3	12
Total Percentage	30	30	20	20	100

Note: The difference in cost by level of audience may be more related to dissemination costs than measurement costs.

Scale-Up

Subgroup 3 noted that BASICS thinking about scaling up its community programs should go beyond the identification of specific programs that can be replicated; rather, the focus should be on institutionalizing a system for supporting community programs at a scale appropriate for given target groups and settings. The system needs to be compatible with the country situation and capacity and suited to project time frame. Programs should not limit themselves to high-risk populations only, since the resources of the larger community can be an invaluable asset in starting up and sustaining program activities. The goal then is to implement a coordinated package of complementary strategies to achieve maximum impact on a broad scale.

Constraints

The absence of political will and a supportive national policy can be frequent impediments to scaling up country programs. The health status of the population often is not a top government priority; national resources and attention are focused elsewhere. However, national policy is not necessarily the starting point for broad-based programs; important programs such as IMCI can drive national policy rather than vice versa. Political hijacking of programs by national governments poses an occasional threat (BASICS/Nigeria seems to be faced with this potential problem, although it has managed, on the basis of lessons learned in Lagos, to scale up the program by taking it north to Kano).

Organizational structure in the program country can be a major barrier to scaling up. The global trend at this time is toward decentralization, especially in Africa, with the ensuing devolution of taxation and spending powers. A decentralized health sector can mean not only an absence of central structure for promotion and facilitating of scaling up, but also a crippling shortage of health workers and resources at various levels of the system—national, regional, and local. Other serious questions arise as well, such as who is going to be the repository of institutional memory? Who will assume the responsibility for coordinating scaling up? The NGO sector is playing an increasingly larger role as public support for social development weakens. This may be a desirable outcome, but progress is often hampered by a generally weak and contentious relationship between governments and NGOs. Besides, the NGOs themselves in many instances suffer from inadequate management capabilities. This is where BASICS can make a significant contribution.

Partners for Success in Scaling Up

Scaling up community programs requires effective partnerships among a variety of stakeholders. Key partners include the ministry of health, NGOs, donors, the commercial sector, private providers, and media organizations.

Government/NGO Collaboration

An obviously felt need is to strengthen collaboration between ministry-level structures and the NGOs. One approach to such collaboration could be an intermediary umbrella body. Meanwhile, BASICS should play a role in strengthening the capacity of the partners in participatory assessment, planning, and implementation of projects at various levels—Ministry of Health, NGOs, and other related organizations—sharing tools and experiences, organizing visits and workshops, developing and disseminating IEC modules and materials, and documenting and disseminating information to build a "learning institution." Demonstrating and publicizing projects that are possible and inexpensive and that therefore can be replicated on a national scale within given resource restraints should also be considered.

As an exception to the norm, the program in Nigeria had to forgo any collaboration with the government or even access to government health facilities because of the U.S. Government's sanctions against the regime. The existing coordinating body was too autocratic, so the project created a new NGO coordinating body. Other exceptions might be projects that are not implemented through NGOs, thus requiring direct links between the government and the communities. In Zambia, the communities taught the districts the process of community participation after BASICS had taught them.

Private/Commercial Sector's Role in Scale-Up

An important and largely untapped resource for significant scale-up is the private/commercial sector. The opportunities for leveraging and mobilization certainly exist. The commercial sector can make important contributions through the provision of products and services (examples include social marketing of oral rehydration salts in India and contraceptives in Indonesia). Companies can be useful in identifying products and geographic areas. In addition to national campaigns, BASICS could look at small-scale interventions, which, if successful, can be expanded by the private sector. BASICS can play a major role here not only by getting the private companies involved in programs and helping them create a market that they can then expand on their own, but also by training the producers and providers to market themselves.

Provider networks. BASICS could also try to identify groups of trained private providers that can be coalesced into a network that can be marketed with the government's "seal of approval." The mass media can play a major role in scaling up prevention programs by creating awareness and demand in areas where community approaches are being implemented. BASICS can work with national IEC task forces and committees to develop plans and materials, as has been done in Madagascar.

Government and private sector linkages. Collaboration between governments and the private sector can facilitate scale-up of programs and be mutually beneficial. Governments can scale up social marketing campaigns that are planned in collaboration with the private sector by easing up on privatization and regulatory issues, and the private sector can help by contributing important resources for advertising and promotion. The private sector focus on getting involved in "cause-related marketing" makes sense to big businesses (mainly as a way of improving their image), but the bottom line is always profit. Thus, the range of incentives and benefits needs to be carefully examined in involving the private sector in scaling up. Perhaps USAID can look into building bridges with international companies. The private sector approach, however, should be tempered with ethical considerations and caution to forestall potential problems. In India, for example, drug companies have created a huge demand for drugs, which the public health promoters now have to deal with.

Zambia is successfully tapping social and private sector organizations such as the Rotary International, Lion's Clubs, and Lever Brothers for contribution pledges. Employer-based programs report successes as well (e.g., Project HOPE's collaboration with tea estate companies in Malawi to bring preventive care services to the estate employees; BASICS/Zambia is currently exploring opportunities for a similar project with zinc mining companies). In looking at innovative approaches, a suggestion was made in the group to explore the possibility of involving major airlines in collecting donations from passengers—Finn Air and British Airways are already doing this for UNICEF.

As a final suggestion in this discussion, BASICS should explore the opportunities for introducing training in community participation processes and techniques to preservice institutions and schools as well as to relevant professional groups such as agricultural workers and other local cadres working in communities.

Chapter 4
Conclusions and Framework for the Future

Closing Discussion

BASICS community-based programs can be best characterized along a continuum of community involvement in the decision-making process. In *Model 1* programs, such as those in Honduras, Madagascar, and Bangladesh, BASICS approaches the communities within a predetermined structure with identified goals and actions from which the community can select those it deems most important; *Model 2* programs, such as those in Nigeria and Zambia, are more open-ended, and the communities participate in appraisals of the prevailing situation relating to health, help develop action plans, and become partners in implementation. Both models (or approaches) have strengths.

As an example of Model 1, AIN in Honduras has been able to use a growth monitoring program to train community volunteers to counsel mothers, organize community meetings to mirror the community's nutritional status, and motivate the community to solve its health problems. As a national program, AIN is able to systemize the recruitment, curriculum, and training of volunteers and maintain them on a long-term basis as well as add new elements to the program. Similarly, the Hearth program succeeded in jump-starting a cadre of volunteer mothers as community health workers through its nutritional rehabilitation program.

As examples of Model 2, both Zambia and Ethiopia have used data collection to involve the community in a decision-making process rather than a prestructured program. Although desired behaviors were predetermined, the community, in a joint process with health workers, was free to select the behaviors it saw as high priority, help develop action plans, and implement interventions. By standardizing action plans (norms, content, training, materials, and messages) and by evaluating and documenting the experience, Model 2 programs can be successfully scaled up. By helping the community to gain awareness, experience, and a sense of ownership and demonstrating visible positive outcomes, this type of programming may have a better chance of being sustained after outside support is terminated and perhaps even of being more impervious to political upheavals than programs that are planned and implemented from the top.

BASICS's Future Role

Any discussion of BASICS's future role in community-based health programs needs to begin with a recognition of the specific context in which the project exists. As a USAID-funded child survival project, BASICS is subject to certain policy and regulatory constraints. USAID's mandate is to lift those who are not being lifted in other ways, and its resources are finite. Fifty percent of morbidity happens in 25 percent of the families in developing countries. The stratum of those most in need of public health services is 15 percent to 20 percent of the population in most countries where USAID provides support. Community-based approaches are especially relevant for such highest-risk populations, which are often rural with poor access to formal health services.

So far, BASICS has worked primarily at the national and district levels to provide technical assistance and support to ministries of health with a focus on health facilities. That is where it can continue to be most effective by building the capacity of the ministries and by integrating its health agenda into the national policy and planning process. BASICS's focus on specific health behaviors to ensure specific outcomes is the special strength of its programs. Focused and targeted programs with clearly defined goals, expectations, and responsibilities have a better chance of success and are more amenable to replication and scale-up. Training and local capacity building help programs to take root and be sustained after BASICS is gone.

In addition, BASICS has achieved a good deal of credibility in the international health arena, and it can be a catalyst in shaping global health policies and initiatives. By further expanding and strengthening its collaborative activities with international donor agencies, BASICS can make a significant contribution in the field of child survival.

The essential elements of BASICS evolving role should include the following:

- Policy advocacy and planning to promote equity and standardize community planning processes
- Fostering of partnerships between ministries of health and the private sector, including PVOs and NGOs, private health providers, and the commercial sector
- Information dissemination about successful strategies for achieving greater impact at the community level
- Capacity building in both public and private institutions to sustain implementation of community-based programs

These roles are further detailed in Table 8. Finally, while it may be premature to attempt to formulate a definitive list of criteria by which the project's future work is to be guided and judged, the workshop participants agreed that in addition to building on the successful strategies identified during the workshop, BASICS should strive to ensure that its community-based work is—

- C Effective (achieves impact on health behaviors),
- C Replicable,
- C Sustainable, and
- C Participatory (within existing constraints).

Each of these criteria on its own may be difficult to realize, and the pursuit of one may be at cross-purposes with another—for example, effectiveness versus sustainability. BASICS should nonetheless attempt to define approaches that can meet all of these criteria—or at least strike a balance among

them—if the project is truly to move beyond old community participation paradigms and provide leadership in this important area.

Table 8. Fostering Partnerships to Increase Child Health Impact at the Community Level

Level	Partners	BASICS's Roles	Tools
National	–Ministry of Health –Other ministries with extension services –National NGOs/PVOs –Donors –Private provider associations –Commercial sector –Media	–Conduct advocacy for increased emphasis on community health –Develop national strategies/plans for scale-up –Facilitate coordination among donors –Facilitate partnerships between MOH and private sector –Test approaches for involving commercial sector –Develop national media support for community initiatives –Document and disseminate successful community approaches	–SARA Advocacy Guide –BASICS Guide to Mobilizing Commercial Sector –BASICS/SARA Guide to Communication in Support of IMCI –BASICS Methodology for Assessing PVO Best Practices –BASICS Process and Cost Evaluations of Community- Based Programs –BASICS Methodologies for Assessing Private Medical Sector
District Level	–District health management teams –Local NGOs –Agricultural and other extension networks	–Facilitate partnerships between MOH and local NGOs –Train district health teams and NGOs in planning and assessment of community approaches –Assist development of new community financing schemes, such as district grants to NGOs	–BASICS Emphasis Behaviors Approach –BASICS Guide to Participatory Community Planning –BASICS/UNICEF Guide to Participatory Communication
Community Level	–Health facility staff –Community leaders –Community-based organizations –Women's groups –Schoolteachers –Private health providers	–Provide technical assistance to promising community demonstration projects (e.g., Centers of Learning) –Assist evaluation and dissemination of successful approaches	–BASICS Tool Box on Monitoring and Evaluation

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